SNELLER
FAMILY DENTISTRY

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text? ☐Y ☐N

Email: _____

SS# _____ DOB: _____ Sex: ☐ M ☐ F

☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐ Separated

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Who should we thank for referring you? _____

Emergency Contact: _____ Phone: _____

Parents or Spouse: _____

Primary Insurance

Person Responsible for Account: _____

Relationship to Patient: _____ DOB: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text? ☐Y ☐N

Responsible Party Employed By: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

Additional Insurance

Insured Name: _____

Relationship to Patient: _____ DOB: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text? ☐Y ☐N

Insured Employed By: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

I hereby authorize payment directly to SNELLER FAMILY DENISTRY for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____