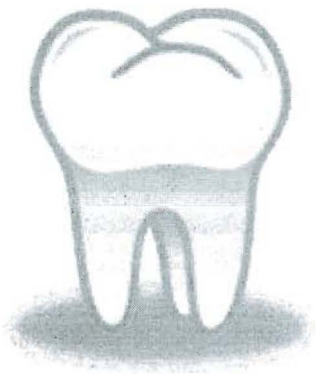

Welcome to Marion Family Dental

Patient Information

Patient Name _____ Date_____

Billing Address_____

City_____ State_____ Zip code _____

Home Phone(___)_____ Cell Phone_(___)_____

Work # _(___)_____ Other # _(__)_____

Which of the above phone numbers should we use FIRST to contact you regarding dental? Please circle: Home Cell Work

Patient's Social Security #_____ Patient's Date of Birth:_____ Male Female (circle one)

Check one: [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

Email Address_____ Driver's License_____ State Issued _____

If Student, Name of School/College_____ City/State _____Full Time [ ] Part Time [ ]

Name of Patient's Employer_____

Address & Phone No. of Patient's Employer_____

Name of Spouse_____ Phone No. of Spouse_____ Date of Birth of Spouse _____

Spouse's Social Security #_____ Spouse's Employer_____

Address & Phone No. of Spouse's Employer_____

From whom or where did you hear about our dental office? _____

DENTAL INSURANCE INFORMATION

Please provide us with your insurance card(s)

_____ _____ _____

Name of Dental Insurance Co. Name of Policyholder Date of Birth of Policyholder

Phone No. of Dental Insurance Co._____ Policy/ID No._____

Is there a secondary dental insurance? (Please circle) Yes No If yes, please fill-out information below:

Secondary Dental Insurance Co._____ Phone No _____

Name of Policyholder of Secondary Insurance_____ Policy ID No._____

Phone No. of Secondary Ins. _____ Date of Birth of Policyholder_____

Assignment & Release

I hereby authorize payment directly to Marion Family Dental for all insurance benefits otherwise payable to me for services rendered. I authorize the above clinic to release the information required to secure payments for benefits received. I authorize the use of the signature on all insurance submissions. I am responsible for applicable co-payments and / or deductible.

_____ _____ _____

Signature of Responsible Person Relationship to Patient Date