PATIENT INFORMATION PAGE 1

PATIENT

PATIENT LAST NAME	FIRST	MIDDLE	PREFERRED NAME TO BE CALLED	☐ MALE ☐ FEMALE	TODAY'SDATE
BIRTH DATE	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	MARITAL STATUS ☐S ☐M ☐W ☐D	
MAILING ADDRESS			CITY	STATE	ZIP CODE
HOME ADDRESS			CITY	STATE	ZIP CODE
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				RELATIONSHIP	

IF PATIENT IS UNDER AGE 21

MOTHER'S NAME	IF PARENTS ARE DIVORCED, WHO HAS:
	LEGAL CUSTODY? ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER
FATHER'S NAME	FINANCIAL CUSTODY? ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER

PATIENT/PERSON ACCOMPANYING PATIENT TODAY WHO IS RESPONSIBLE FOR PAYMENT:

LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO PATIENT ☐PARENT ☐SPOUSE ☐LEGAL GUARDIAN ☐OTHER	
SOCIAL SECURITY NUMBER	PRIMARY PHONE #		SECONDARY PHONE #	
HOME ADDRESS ☐SAME AS ABOVE			CITY	STATE	ZIP CODE

PRIMARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

PRIMARY MEDICAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

PLEASE CONTINUE TO PAGE 2

PATIENT INFORMATION PAGE 2

PATIENT'S NAME_____

SECONDARY DENTAL INSURANCE ☐ **NONE**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #	

SECONDARY MEDICAL INSURANCE ☐ **NONE**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #	

_____I understand that all payments for services are due on the date they are provided. After the receipt of insurance payment(s), my account balance is due within 14 days. Amounts received in excess of my account balance will be refunded to me.

_____I understand that if I do not wish to provide my social security number I will be responsible to pay in full Dr. Banks' usual and customary fees for any services provided at the time the services are provided. I understand that I will be relinquishing my right to apply any negotiated insurance contract fees to my account balance, as well as the ability of Dr. Banks to submit insurance claims on my behalf.

_____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____
PRINTED NAME OF PATIENT PARENT OR GUARDIAN

_____
TODAY'S DATE

_____
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF
DR. KATHY A. BANKS