RC Dental Group Patient Information

Patient Name: _____ Birth Date_____

Parent/Guardian Name: _____

Last First MI

□ **Male** □ **Female** □ **Married** □ **Single** □ **Child** □ **Other** _____

Social Security #:_____ Driver's License #:_____ State:_____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (Home):_____ Work:_____ Ext:_____ Cell:_____

E-Mail: _____ Fax: _____

Emergency Contact Information

Name: _____ Phone #: _____

Relationship: _____ Alternate # _____

Primary Insurance Information

Name of Insured: _____ Relation to patient : □ Self □ Spouse □ Child □ Other

Last First

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: □ Same as Patient or _____

Street city state zip

Insurance plan name: _____ Ph#: _____

Employer Name and phone #: _____

Secondary Insurance Coverage

Name of Insured: _____ Relation to patient : □ Self □ Spouse □ Child □ Other

Last First

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: □ Same as Patient or _____

Street city state zip

Insurance plan name: _____ Ph#: _____

Referral Information

Who may we thank for referring you to our office? □ Existing Patient, Friend □ Another Doctor □ Dental Office

Name of person or office referring you to our practice: _____

Consent

I authorize RC Dental Group Associates and staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my dependant's) dental care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my dependant's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole by my dental insurance. I grant my permission to you and your assignee to telephone me at any telephone # provided to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Signature of patient, parent or guardian Date Relation to patient