Confidential Dental and Medical History

Patient's Name _____ Age_____ Date of Birth _____

Address _____City, State, Zip_____

Home Phone _____Work _____Cell _____

E-mail _____

Best Contact- **Email Cell Text Home** Best Time to Reach You- _____

SS# _____ Marital Status: **Single Married Widowed Divorced**

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Phone:_____

Emergency Contact _____Relation _____ Emergency Phone _____

Do you have dental insurance? **YES NO**

If YES, Insurance Carrier's Name _____

Group # _____ Phone _____ Subscriber's Name _____

Subscriber's SS or Mem ID# _____ Subscriber's Date of Birth _____

Employer/Co. Name _____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address, City, State, Zip _____

HOW DID YOU HEAR ABOUT US ? _____

Would you like to receive appointment reminders via text message? **YES NO**

Would you like to become friends with The Bite Dental on facebook.com to receive special offers? **YES NO**

OFFICE POLICY REGARDING INSURANCE:

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to The Bite Dental at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (30) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____ _____

Signature of Patient or Guardian Date