River Ridge Dental

General Dentistry including Orthodontics

Patient Information

Name _____ Social Security # _____
(First) (Initial) (Last)

If Minor, Parents Name _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email Address _____

Sex: Male Female Age _____ Birthdate _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Seperated ❑ Domestic Partner

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

How do you prefer to be contacted regarding future appointments: Home # Cell # Email

Whom shall we contact in case of emergency _____ Phone: _____

Whom may we thank for referring you _____

■ Primary Insurance ■

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Company _____ Phone _____

Group # _____ Subscriber ID _____

Names of other dependents under this plan _____

■ Secondary Insurance ■

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Home Phone: _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Dental Insurance Company _____ Phone _____

Group # _____ Subscriber ID _____

Names of other dependents under this plan _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to River Ridge Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____