Bitterroot Valley Dental Care

PATIENT INFORMATION Date_____

Name_____ Nickname_____

Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____

Birth date_____ Soc. Sec #_____ Sex: F M

Email address _____

Employer_____ Work #_____

Address_____City_____ State_____ Zip_____

If student, name of school/college_____ Full____ Part____

Person to contact in case of emergency_____

Relationship to patient_____ Phone #_____

Whom may we thank for referring you?_____

DENTAL INSURANCE INFORMATION

Subscriber name_____ Birth date_____

Address_____ City_____State_____ Zip_____

Soc. Sec#_____ Relationship to patient_____

Employer_____ Insurance Company_____

Group #_____ID # _____ Phone_____

Secondary Insurance:

Subscriber name_____ Birth date_____

Address_____ City_____State_____ Zip_____

Soc. Sec#_____ Relationship to patient_____

Employer_____ Insurance Company_____

Group #_____ID # _____ Phone_____

I authorize and request my insurance company to pay directly to Bitterroot Valley Dental Care, insurance benefits otherwise payable to me. I understand that I am responsible for payment of all services provided.

Signature_____ Date_____

AUTHORIZATION AND RELEASE

I authorize the use and disclosure of my health information for treatment, payment, and healthcare operations. I understand that the Notice of Privacy Practices is posted and I may request a copy at any time. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____ Date_____