EPIONE DENTISTRY

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I._____

Preferred Name _____ DOB: _____ ☐ Male ☐ Female SSN:_____

Street Address:_____ City:_____ State:____
ZIP_____ Email: _____

Home (_____)_____ Work (_____)_____ Mobile (_____)_____

How would you like to receive appointment reminders? (Please circle): Phone Call Email Text

Emergency Contact

Name: _____ Relationship:_____Phone: (_____)_____

Employer: _____ May we contact you at work? ☐ Yes ☐ No

How did you hear about us? _____

DENTAL INSURANCE

Primary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone #: _____

Employer: _____Group #: _____Relation to patient: _____

Secondary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone #: _____

Employer: _____Group #: _____Relation to patient: _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

_____ _____
Patient Signature or Responsible Party Date

_____
Relation to Patient