MOUNTAIN LOOP
DENTAL

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Welcome to our office. We appreciate the confidence you place with us to provide dental service. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT'S NAME _____

Preferred Name _____ Sex ☐F ☐M ☐Other

☐Married ☐Single ☐Other _____

Birthdate _____

Mailing Address _____

City _____ Zip _____

Home Phone _____ Cell _____

Work Phone _____ Ext # _____

Soc. Security _____

Patient Occupation _____

Employer _____

SPOUSE INFORMATION

Name of Spouse _____

Birthdate _____

Cell _____

Work Phone _____ Ext # _____

Soc. Security _____

Occupation _____

Employer _____

How can we best reach you for general questions and confirming appointments?

☐Cell ☐Text ☐Work ☐Home

Email _____ Time of Day _____ ☐AM ☐PM

Whom may we Thank for referring you? _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Hm Phone _____ Wk Phone _____

Relationship to Patient _____

Physician's Name _____ Phone _____

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PRIMARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone _____

Insurance ID _____

SECONDARY DENTAL INSURANCE

Employee _____

Employer _____

Insurance Co. _____ Group# _____

Phone _____

Insurance ID _____

Person responsible for payment _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf.

_____

Signature

_____

Date

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