WOODBURY DENTAL Care

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth_____ Marital Status: Single ◯ Married ◯ Sex: Male ◯ Female ◯ SSN _____

Address _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Referred By _____

i.e. friend (name), website, internet search, etc.

Emergency Contact

Name _____ Relation _____ Phone _____

Insurance Information

Primary Insurance

Subscriber's Name _____

Subscriber's Birthdate _____ ID or SSN _____

Subscriber's Employer _____ Group No. _____

Secondary Insurance

Subscriber's Name _____

Subscriber's Birthdate _____ ID or SSN _____

Subscriber's Employer _____ Group No. _____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing, and processing of insurance benefits for which I am entitled. I understand that I am responsible for payment regardless of insurance coverage, and that finance charges will be applied to balances over 60 days. Credit bureau reports may be obtained. I have received a copy of the Notice of Privacy Practices, and consent to your use of my protected health information.

Signature of Patient / Parent _____ **Date** _____