LANSDOWNE
DENTISTRY
BY DESIGN

WELCOME

Please take a few minutes to complete the following confidential information.
If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Date _____ Social Security # _____ Birth Date _____

Address _____

Last Name _____ First Name _____ Home Phone _____

City _____ State _____ Zip _____

❑ Male ❑ Female Age_____ ❑ Single ❑ Married ❑ Divorce ❑ Widowed

E-Mail Address _____ Cell Phone _____

Where can you be reached during the day? ❑ Home ❑ Work ❑ Cell ❑ E-mail

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Closest relative not living with you _____ Phone _____

Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with *(Name of Insurance Company)* _____

and assign directly to your dentist all 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 insurance for myself and/or minor children. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature _____ Date _____

PRIMARY DENTAL INSURANCE

Employee (Subscriber) _____

Insurance Company _____ Group # _____

Employer _____

Business Address _____ Phone _____

Occupation _____

Employee date of birth _____ Social Security # _____ Date employed _____