Patient Information

Name: _____ Date of Birth: _____ SSN: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Home Address: _____
Street Apartment # City State Zip Code

Best e-mail for appointment reminders and info: _____

Referral Information

Whom may we thank for referring you to Forest Acres Dentistry? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Internet Search ☐ Social Media ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party for Payment / Insurance Guarantor (IF different from Patient)

The following is for: ☐ the patient's spouse ☐ the patient's guardian(s) ☐ other: _____

Name: _____ Date of Birth: _____ SSN: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Home Address: _____
Street Apartment # City State Zip Code

Employment Information for Responsible Party for Payment / Guarantor

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

For Minor's only: Co-Guardian Information (different from Guardian that is the Guarantor)

Name: _____ ☐ Male ☐ Female Relationship to patient: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Home Address: _____
Street Apartment # City State Zip Code

Insurance Information

Primary Insurance

Name of Guarantor: _____ Is the guarantor a patient? ☐ Yes ☐ No
First MI Last

Insurance Plan Name: _____ ID #: _____ Group #: _____

Guarantor's Address (if different from above): _____
Street City State Zip Code

Guarantor's Employer Name (if different from above): _____

Patient's relationship to guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance

Name of Guarantor: _____ Is the guarantor a patient? ☐ Yes ☐ No
First MI Last

Insurance Plan Name: _____ ID #: _____ Group #: _____

Guarantor's Address (if different from above): _____
Street City State Zip Code

Guarantor's Employer Name (if different from above): _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

The above information is correct, to the best of my knowledge.
I hereby authorize payment directly to Forest Acres Dentistry of the group insurance benefits otherwise payable to me.

_____ Date: _____
Signature of patient, parent, or guardian

If you are not the patient, please list your relationship to the patient: _____