

WELCOME

Today's Date _____

Patient Information

Patient Name _____ Preferred _____
Last First MI

Sex: male female Status: minor single married divorced other

Birthdate _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone# _____ Work# _____ Ext # _____

Cell Phone# _____ E-mail _____

Employer _____ Address _____

Who may we thank for referring you to us? _____

Emergency Contact _____ Phone# _____

Primary Insurance Information

Insurance Co. Name _____ Phone# _____

Subscriber Name _____ Birthdate _____ SS # _____

Relationship to patient _____ Employer _____

Subscriber ID # _____ Group # (plan or policy) _____

Secondary Insurance Information

Insurance Co. Name _____ Phone# _____

Subscriber Name _____ Birthdate _____ SS # _____

Relationship to patient _____ Employer _____

Subscriber ID # _____ Group # (plan or policy) _____

Person Responsible For Account

Name _____ SS# _____ Phone # _____

Billing Address _____ Relationship to Patient _____

Authorization: I hereby authorize payment directly to Dr. Jeffrey J. Tibbs, DDS, PA for all insurance benefits otherwise payable to me for services rendered, and the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants. I understand it is my responsibility to notify the dental office of any changes to my insurance benefits. I acknowledge that the dental office reserves the right to request payment in full at the time services are rendered.

_____ I acknowledge that I have received a copy of the Summary of Privacy Notice & Financial Policy.

Initials
Signature _____ Date _____