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? _____

*EmergencyContact*_____*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***_____