HERRICKDENTAL

Welcome! Thank you for selecting our dental team to provide you with the best possible dental care!

Name____ Preferred Name_____________________________

Address____________________________________City:________________________State:_______Zip___________

SSN_______________________________________DOB____________________________ ☐ Male ☐ Female

Home Phone______________________ Work Phone______________________ Cell Phone______________________

Email___________________________________ Referral Source ____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact______________________________Relationship_________________Phone__________________

Insurance-Primary

Subscriber Name__________________________ Relationship to Patient_______________ Subscriber DOB__________

Subscriber ID/SSN___________________________ Subscriber Employer____

Insurance Company Name____________________________________ Employer ________________________________

Insurance-Secondary

Subscriber Name__________________________ Relationship to Patient_______________ Subscriber DOB__________

Subscriber ID/SSN___________________________ Subscriber Employer____

Insurance Company Name_____________________________________ Employer _______________________________

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Herrick Dental all insurance 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. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

*****Responsible Party Signature_______________________________________**

Relationship____ **Date**________________________________