

PATIENT INFORMATION

PATIENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL

PREFERRED NAME

ADULT

CHILD

CHILD UNDER
GUARDIANSHIP

NAME OF GUARDIAN, IF APPLICABLE

DATE OF BIRTH

PATIENT'S GENDER

MARITAL STATUS

PATIENT STREET ADDRESS

CITY / TOWN

POSTAL CODE

MOBILE

HOME PHONE

WORK PHONE

By which way do you prefer to communicate with us?

•

EMPLOYER

OCCUPATION

NAME

RELATIONSHIP

HOME PHONE

WORK PHONE

HOW DID YOU HEAR ABOUT US? Please check
referral

FRIENDS/FAMILY (Please name to thank them)

INSURANCE COVERAG

POLICY HOLDER NAME

POLICY HOLDER DOB

EMPLOYER

INSURANCE PROVIDER

POLICY #

CERTIFICATE/ID #

PROVIDE COPY OF INSURANCE CARD

• I authorize Trinity Family Dental to submit any necessary pre-determinations inquiring further information about my dental benefits for recommended treatments.

• I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history. I realize that the dentist is a general practitioner who offers main specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

• I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

• I consent to the responsibility for payment of the dental service for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires 2 business days notification to avoid any minimum charges.

Name of the authorizing person

Submission Date