MOUNTAINS WEST DENTAL

Welcome....We are pleased to welcome you to our clinic. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

NAME_____DATE_____

MAILING ADDRESS_____

PHYSICAL ADDRESS_____

DATE OF BIRTH_____AGE_____

MARTIAL STATUS_____SPOUSE_____

HOME PHONE_____CELL PHONE_____

SSN#_____DRIVERS LICENSE_____

Name of Person responsible if **PATIENT** is a **MINOR**_____

ADDRESS (if different from above) _____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____WORK PHONE_____

EMERGENCY CONTACT_____PHONE_____

RELATIONSHIP (spouse, friend, co-worker, etc.)_____

Whom may we thank for referring you to our office? _____

PRIMARY INSURANCE INFORMATION

Policy Holder_____SSN#_____

Address_____

Date of Birth_____Relationship to patient_____

Employer_____Phone_____

Insurance Co._____Group#_____

Insurance Address_____

SECONDARY INSURANCE INFORMATION

Policy Holder_____SSN#_____

Address_____

Date of Birth_____Relationship to patient_____

Employer_____Phone_____

Insurance Co._____Group#_____

Insurance Address_____

I authorize my insurance company to pay the clinic all insurance benefits otherwise payable for services rendered.
I authorize the clinic to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature_____**Date**_____