Salmon Creek Family DENTAL

Please help us by providing the following information.

Patient Information:

Name:_____ Preferred_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address:_____ SS#_____ Drivers License#_____

Spouse's Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

In the event that we must contact you for scheduling changes, emergencies, etc., please indicate the best NUMBER to reach you during business hours:_____

Dental Insurance Information:

Primary Insurance Company:_____ Phone:_____

Name of Insured:_____ Relationship:_____

Date of Birth of Insured:_____ SS# of Insured:_____

Employer:_____ Phone:_____

ID#:_____ Group #:_____

Is there Secondary Insurance? Yes No

Secondary Insurance Company:_____ Phone:_____

Name of Insured:_____ Relationship:_____

Date of Birth of Insured:_____ SS# of Insured:_____

Employer:_____ Phone:_____

ID#:_____ Group #:_____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Dale Nelson, DMD and Salmon Creek Family Dental of insurance benefits to which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless the other financial arrangements have been previously made.

Patient's Signature:_____ Date:_____

FORM #161071