TOPSAIL DENTAL

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## PATIENT INFORMATION

**First Name:_____ Last:_____ MI_____**

**Address:_____ City:_____ State/Zip:_____**
**Birth Date:_____ Age:_____**
**Gender: _____ Social Security Number:_____**
**Marital Status: *Married *Single *Child *Divorced *Widowed**
**Home #_____ Cell#_____ Work#_____**
**Email:_____ Pharmacy #_____ Who Referred You?_____**

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**In the event of an Emergency**

**Contact Name_____ Relation_____**
**Home#_____ Cell#_____ Wk#_____**

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## MEDICAL INSURANCE

***Please provide us with your insurance card so that we can make a copy for your records.***

**Insurance Co. Name:_____**
**Address:_____ Phone:_____**
**Employer:_____ Group#_____**
**Insured's Name:_____ Relation:_____**
**Insured's Birth date:_____ Insured SSN:_____**

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## DENTAL INSURANCE

***Please provide us with your insurance card so that we can make a copy for your records.***

**Insurance Co. Name:_____**
**Address:_____ Phone:_____**
**Employer:_____ Group#_____**
**Insured's Name:_____ Relation:_____**
**Insured's Birth Date:_____ Insured SSN:_____**

**Easy Pay Consent**

**To accept assignment of benefits, we now require a credit card to be left on file with our office**. I (the patient) authorize **TOPSAIL DENTAL** to keep my signature on file and to **Credit** my card in the event a refund is issued **and/or Charge** my card in the event a balance of less than $100 is due 60 days beyond the date of service. I understand this agreement and commit to payment unless I cancel the authorization through written notice to Topsail Dental and provide alternative payment. **Your card number will be placed under password protection connected to your account**. I understand that this credit card information will be kept highly confidential. **Please inquire about our options for fitting your dental treatment cost into your budget.**

TOPSAIL DENTAL

**Signature:_____**