DUNKIRK
DENTAL

Welcome

Patient Information

Please Check One: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms.

Name: (last) _____(first) _____ (middle initial) ____

Street Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ /_____ /_____ Email Address:_____

Home Phone: _____Cell Phone: _____

Employer: _____Work Phone: _____

What is your preferred method of contact? (check one) ( ) Home ( ) Cell ( ) Work ( ) Email

How did you choose our dental office? (check all that apply): ( ) Website ( ) Location ( ) Hours

( ) Signage ( ) Family/Friend ( ) Yellow Pages ( ) Other: _____

Emergency Contact Name: _____ Phone: _____

Account Holder Information

Please Check One: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms.

Name: (last) _____(first) _____(middle initial) _____

Street Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ /_____ /_____ Email Address: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____Employer: _____

Spouse's Name: (last): _____ (first) _____

(over)

Insurance Information

Policyholder's Name: _____Relationship to Patient: _____

Date of Birth: _____ /_____ /_____

Insurance Company: _____

Address: _____

ID #: _____Group # _____

Employer: _____

DO YOU HAVE DUAL COVERAGE? ( ) No ( ) Yes - If yes, please complete the following:

Policyholder's Name: _____Relationship to Patient: _____

Date of Birth: _____ /_____ /_____

Insurance Company: _____

Address: _____

ID #: _____Group # _____

Employer: _____

I authorize Dunkirk Dental to submit claims to my insurance company, and request that my insurance company pay benefits direct to Dunkirk Dental. I agree to full financial responsibility of all charges for treatment rendered, regardless of insurance involvement.

I certify that the information I provided for treatment and payment is accurate.

_____
Signature (parent or legal guardian signature if patient a minor)

_____
Print Name

_____
Date:

Thank you for choosing Dunkirk Dental!