bothell family dental care

Patient Information

Name _____ **Preferred name** _____
Last First Middle

☐ **Male** ☐ **Female**

Birthdate _____ **Social Security #** _____ ☐ **Single** ☐ **Married**

Address _____
Street address City State Zip Code

Employer (or school) _____ **Email address** _____

Cell Phone _____ **Home Phone** _____ **Driver's License #** _____

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

Insurance Information

Primary Insurance Carrier (if applicable)

_____
Name of insured and birthdate (if different than patient)

Company _____

ID # / SSN # _____

Group # _____

Secondary Insurance Carrier (if applicable)

_____
Name of insured and birthdate (if different than patient)

Company _____

ID # / SSN # _____

Group # _____

Emergency Contact Information

Name _____ **Phone Number** _____ **Relationship** _____

Name _____ **Phone Number** _____ **Relationship** _____

Acknowledgement and Authorization

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. Our notice is available online, in paper, and by brochure. I have been given the opportunity to ask any questions I may have regarding this notice. I hereby authorize the Bothell Family Dental Care (BFDC) to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The Information on this page and the medical history are correct to the best of my knowledge. The undersigned agrees he/she hereby individually obligates himself/herself to pay for treatment received at BFDC in accordance with the regular rates and terms of the office. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me.

Signature of Responsible Party

X_____ **Date** _____

☐ **Self** ☐ **Mother/Father** ☐ **Legal Guardian** ☐ **Power of Attorney** ☐ **Other:** _____

If signing on behalf of a minor or under power of attorney, please provide the following information:

Name _____ **Birthdate** _____ **Relationship** _____

Address (if different than patient) _____

Phone number _____ **Email** _____