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** _____