WELCOME TO BOULDER VALLEY DENTAL CENTER!
GENERAL PATIENT INFORMATION

PATIENT INFORMATION

Name: _____
Last First Initial

Preferred Name: _____

Gender: Male ☐ Female ☐

Marital Status: (circle one)
☐ ☐ ☐ ☐ ☐ ☐ ☐
Single, Married, Separated, Divorced, Widowed, Minor, Other

Date of Birth: _____ Age: _____

Social Security Number: _____-_____-_____

Driver's License: State_____
Number_____

Home Phone Number: (____)_____

Cell Phone Number: (____)_____

E-mail Address: _____

HOME ADDRESS

Address: _____
City, State, Zip _____

Who is responsible for this account?

_____

BILLING ADDRESS

Same as above ☐ Y/N ☐ If no, complete below.
Name: _____
Address: _____
City, State, Zip _____

WORK INFORMATION

Employer: _____
Occupation: _____
Work Phone Number: _____

SPOUSE OR PARENT INFORMATION

Name: _____
Gender: Male ☐ Female ☐
Date of Birth: _____ Age: _____
Social Security Number: _____-_____-_____
Employer: _____
Occupation: _____

Other Family Members in Our Practice?

_____
_____
_____

DENTAL INSURANCE

Do you have dental insurance? Y ☐ N ☐
If yes, Dental Insurance Company:

_____
Group Number _____
Subscriber _____
Subscriber ID _____
Insurance Co. Phone #: (_____)_____

How will you be paying for your services today?
Cash ☐ Check ☐ Major Credit Card ☐ Care Credit ☐

EMERGENCY CONTACT (Name of individual not living with you to notify in case of emergency)
Full Name: _____
Phone Number: (_____)_____
Relation: _____

How did you hear about our office?

- ☐ Website
- ☐ Phone Book
  - ☐ Dex
  - ☐ Yellow Book
  - ☐ Echo Pages
  - ☐ The Yellow Pages Book
- ☐ Physician _____
- ☐ Other Dentist _____
- ☐ Mailer
- ☐ Friend, Family or Coworker
  Whom may we thank for your referral?
  _____
- ☐ Other _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care including the possible use of diagnostic x-rays, local anesthetic and fluoride.
I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my health care, advice and treatment to another dentist or healthcare professional.
I hereby authorize payment of insurance benefits directly to the dentist or dental group otherwise payable to me.
I understand my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
I attest to the accuracy of the information on this page.

Patient or Guardian Signature:

X_____
Date: _____/_____/_____

Print Reset