Silver Spring
DENTAL ARTS

PATIENT INFORMATION FORM

Welcome! We are pleased to see you at our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help. We look forward to working with you in maintaining your dental health for years to come.

Today's Date: _______________

PATIENT INFO

Name ____ Sex [ ]M [ ]F Date of birth ____________________

Address ____ Email ___________________________

City ____ State _______ Zip______________

Home Phone (_____)_________________ Cell (_____)_________________ Work (_____)________________

Age ________ Social Security Number __________________________

Status [ ]minor [ ]married [ ]single [ ]widowed [ ]divorced [ ]separated [ ]partnered for ____ years

Employer/School ____ Occupation_______________________

Emergency Contact Name _______________________________________ Phone (_____)_____________

Who may we thank for referring you? ____

PRIMARY INSURANCE

Person responsible for account ______________________________________ Date of birth __________________

Relation to Patient ___________________________________Social Security Number ________________________

Address ____ Email ___________________________

City ____ State _______ Zip________________

Home Phone (_____)_________________ Cell (_____)_________________ Work (_____)__________________

Employer ____ Occupation ________________________

Employer address ____ Email _____________________

City ____ State _______ Zip____________

Insurance Company ____

Insurance address____ Phone (_____)__________________

Member ID ______________________ Group # _______________________ Subscriber # _____________________

Names of other dependents covered under this plan ____

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ADDITIONAL INSURANCE

Is this patient covered by additional insurance? [ ]Yes [ ]No

Person responsible for account ____ Date of birth _________________

Relation to Patient ________________________________Social Security Number ________________________

Address ____ Email ___________________________

City ____ State _______ Zip_______________

Home Phone (_____)_________________ Cell (_____)_________________ Work (_____)_________________

Employer ____ Occupation ________________________

Employer address ____ Email ____________________

City ____ State _______ Zip_____________

Insurance Company ____

Insurance address____ Phone (_____)_____________

Member ID _____________________ Group # ____________________ Subscriber # _____________________

Names of other dependents covered under this plan ____

CANCELLATIONS

Appointment times are reserved exclusively for you. In order to avoid cancellation fees, we do require, and appreciate, at least **48** hours cancellation notice. Thank you.

AUTHORIZATION

I certify that I, and/or my dependents have insurance coverage with the insurance company(ies) listed above, and assign directly to Dr. Mellanie Thompson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Thompson may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature ____ Date __________________
(Patient or Parent/Guardian)

Printed Name ____ Relation [ ]Patient [ ]Parent [ ]Guardian