Metcalf Dental

PATIENT INFORMATION FORM

Thank you for selecting the Metcalf Dental team! Please take a moment to complete the information requested on this form. If you have any questions or need any assistance, please ask us as we are happy to help. And remember, healthy smiles . . . better lives!

Today's Date:_____

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____

Work number:_____ Email:_____

Which is the best number to reach you?_____

We utilize an automated system to remind you of your appointments as well as important information regarding your oral health. Please indicate your preferred method of contact:

❑ Home Phone ❑ Cell Phone ❑Text Cell Phone ❑ Email ❑ Text & Email

Do you require medication prior to dental procedures? ❑Yes ❑No Are you allergic to penicillin? ❑Yes ❑No

Pharmacy Name and Phone Number:_____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Spouse or Parent/Guardian's Name:_____

Spouse or Parent/Guardian's Employer:_____ Work Phone:_____

Emergency Contact Name:_____ Relation:_____

Emergency Contact Number:_____

Is there anyone we may thank for referring you to our practice?_____

RESPONSIBLE PARTY INFORMATION

Name of Person Financially Responsible for This Account:_____

Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____

Work number:_____ Email:_____

Date of Birth:_____ Relationship to Patient:_____

(over please)

Responsible Party Information continued

Driver's License #:_____ SSN:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

Is this person currently a patient of Metcalf Dental? ❑ Yes ❑ No

Payment is expected at time of service at Metcalf Dental. If you have dental insurance, your estimated portion is due at time of service. We accept the following payment methods. Please check the option you prefer:

❑ Cash ❑ Check ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express ❑ Care Credit

INSURANCE INFORMATION (Subscriber Information)

Subscriber Name:_____ Date of Birth:_____

SSN:_____ Relationship to Patient:_____

Employer Name:_____

Employer Address:_____

Insurance Name:_____ Subscriber ID#:_____

Group Number:_____ Policy Number:_____

Insurance Address:_____

Insurance Phone:_____

Do you have additional insurance? ❑Yes ❑No If yes, please complete the following:

Subscriber Name:_____ Date of Birth:_____

SSN:_____ Relationship to Patient:_____

Employer Name:_____

Employer Address:_____

Insurance Name:_____ Subscriber ID#:_____

Group Number:_____ Policy Number:_____

Insurance Address:_____

Insurance Phone:_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information may be illegal, and that I may be prosecuted. I authorize Metcalf Dental to release any information including the diagnosis and the release of records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to Dr. Chris Metcalf and/or Metcalf Dental insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of Patient (or Parent/Guardian if Minor) *Date*