CONFIDENTIAL **ADULT** PATIENT INFORMATION FORM

Dr #_____ Acct #_____

TenderCare Dental Welcomes you!
Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. The better we communicate, the better we can serve you. If you have a question at anytime, please ask us! We will be glad to assist you.

TenderCare® DENTAL OFFICES

1. ABOUT YOU

Today's Date _____
Name _____
Name I'd like to be called_____ M ☐ F ☐
Birthdate_____Age_____SS #_____
Home Address_____Apt #_____
City_____State_____Zip_____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐
Home Phone (___)_____Work Phone (___)_____ Ext_____
Pager (___)_____Other (___) _____
E-mail_____
Driver's license number_____
Employer _____
Employer's Address_____
Present Position_____How long held _____
Other family members seen by us _____
_____
When and where are best times to reach you?_____
Who may we thank for referring you?_____

2. STATEMENT BILLING INFORMATION

Person responsible for this account? _____
Billing Address_____Apt # _____
City_____State_____Zip_____
_____
Home Phone (___)_____Work Phone (___)_____ Ext_____
Driver's license number_____
Employer _____
Relationship to patient _____
Method of payment will be:
Cash ☐ Check ☐ Credit/Debit Card ☐ Insurance ☐ Other ☐

3. SPOUSE INFORMATION

His/Her Name _____
Home Phone (___)_____Work Phone (___)_____ Ext_____
Birthdate_____Social Security No: _____
Driver's license number_____
Employer _____

Nearest neighbor or relative not living with you:
His/her Name_____Relation _____
Address_____Apt # _____
City_____State_____Zip_____
Home Phone (___)_____Work Phone (___)_____ Ext_____

4. INSURANCE

Bold items are required information in order for us to accurately submit your dental claims. FAILURE TO COMPLETE ALL ITEMS IN BOLD WILL DELAY YOUR BENEFITS!!

Primary Insurance

Dental Coverage Yes ☐ No ☐
POLICY OWNER'S NAME_____
POLICY OWNER'S SS # _____
POLICY OWNER'S BIRTHDATE_____
RELATION _____
INSURANCE COMPANY NAME_____
INSURANCE COMPANY ADDRESS _____
City_____State_____Zip_____
INSURANCE COMPANY PHONE # (_____) _____

UNION OR LOCAL GROUP # _____
Program or policy # _____
EMPLOYER_____Contact _____
Employer address_____
City_____State_____Zip_____

Secondary Insurance

Dental Coverage Yes ☐ No ☐
POLICY OWNER'S NAME_____
POLICY OWNER'S SS # _____
POLICY OWNER'S BIRTHDATE_____
RELATION _____
INSURANCE COMPANY NAME_____
INSURANCE COMPANY ADDRESS _____
City_____State_____Zip_____

Union local or group number_____
PROGRAM OR POLICY NUMBER _____
EMPLOYER _____
Employer's address _____
_____

AUTHORIZATION AND RELEASE

If you have dental insurance, we will prepare and submit your dental Claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize payment directly to TenderCare Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including the diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

_____
Signature (Responsible Party) Date