

Patient's full name: _____ Date of Birth: _____ Male Female

If Minor: Parent's Full Name: _____

How do you wish to be addressed? _____ Referred by: _____

Single Married Separated Divorced Widowed Minor

Residence address: _____ City, State, Zip: _____

Phone #1: _____

Phone #2: _____

Business address: _____ City, State, Zip: _____

Phone #1: _____

Email: _____

Patient **or** Parent employer: _____

Spouse name: _____

Who is responsible for this account? _____

Driver's License State: _____ Driver's License Number: _____

Name & phone of someone (not living w/you) to notify in case of emergency: _____

DENTAL INSURANCE - PRIMARY

Policy Holder name:

Policy Holder date of birth:

Social Security #

Employer name:

Insurance Co:

Address:

City, State, Zip:

Policy #

Phone:

Group #

DENTAL INSURANCE – SECONDARY

Policy Holder name:

Policy Holder date of birth:

Social Security #

Employer name:

Insurance Co:

Address:

City, State, Zip:

Policy #

Phone:

Group #

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care:

1.

2.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist of insurance benefits 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, and I am financially responsible for payment 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 by my dental care payer.

I attest to the accuracy of the information on this page

PATIENT OR GUARDIAN'S INITIALS:

DATE:

I UNDERSTAND ALL APPOINTMENTS ARE CONSIDERED CONFIRMED WHEN SCHEDULED AND TO AVOID A MISSED APPOINTMENT FEE (\$25/HALF-HOUR), A MINIMUM OF 24 HOURS NOTICE IS REQUIRED IF I'M UNABLE TO KEEP APPOINTMENT.

PATIENT OR GUARDIAN'S INITIALS:

DATE:

I understand TRU Dental PC posts a copy of their Privacy Practices in their lobby. I also understand I may obtain a copy of TRU Dental,PCs Privacy Practices via:

1. TRU Dental's website: trudentalnm.com

2. Request a copy from TRU Dental's front office

PATIENT OR GUARDIAN'S INITIALS:

DATE:

SUBMIT