



PERSONAL INFORMATION

Patient's Name _____
 First Name _____ M _____ Last Name _____ Preferred Name _____

Mailing Address _____ Birth Date _____
 City, State _____ Zip _____ SSN _____

Email Address _____ Gender Male Female _____
 Home Phone _____ Marital Status Single Married Other _____
 Mobile Phone _____
 Work Phone _____ Employer _____

We offer an electronic messaging reminder service; may we contact you via:
 Text Message Email Both Neither [Preferences can be changed at any time]

How did you hear about our office? Personal Reference Drive-by Phonebook
 Internet search Facebook Google Google Ad Yelp Health Grades Other: _____

If someone referred you, whom may we thank? _____
 In case of emergency, please contact: _____ Phone _____

RESPONSIBLE PARTY INFORMATION (if not self)

Name _____
 First Name _____ M _____ Last Name _____ Relationship to Patient _____

Mailing Address _____ Birth Date _____
 City, State _____ Zip _____ SSN _____

Email Address _____ Gender Male Female
 Home Phone _____ Marital Status Single Married Other _____
 Work Phone _____
 Mobile Phone _____

INSURANCE & EMPLOYER INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____
 Relationship to Patient _____
 Subscriber Contact Number _____
 Subscriber Birth Date _____
 Subscriber ID or SSN _____
 Group Number _____
 Dental Insurance Carrier _____
 Subscriber Employer _____

SECONDARY INSURANCE

Subscriber's Name _____
 Relationship to Patient _____
 Subscriber Contact Number _____
 Subscriber Birth Date _____
 Subscriber ID or SSN _____
 Group Number _____
 Dental Insurance Carrier _____
 Subscriber Employer _____

AUTHORIZATIONS

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Wilson & Wilson 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 hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____.

 Signature Date

 Signature Date