Natural Life Dental

PATIENT INFORMATION

Name:				☐ **Male** ☐ **Female**
Preferred Name:			**SS#:**	**DOB:**
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor		**Employer:**	
			E-mail:	
Cell #:		**Home #:**		**Work/Other:**

PERSON RESPONSIBLE FOR ACCOUNT

Name:		**DOB:**
Relationship:	**Address:**	
SS#:	**City:**	
DL#:	**State:**	**ZIP:**
Employer:		**Work #:**
Cell #:	**Home #:**	**Other:**

Emergency Contact

Name:	**Phone:**	**Relationship:**

Has any member of your family ever been a patient of ours? ☐ Yes ☐ No

Whom can we thank for referring you to us, or how did you hear about our office?

DENTAL INSURANCE

We bill insurance as a courtesy.
If you would like us to help you submit to your insurance, please present your insurance card.

Insured's Name:	**ID #:**

Assignment of Insurance Benefits

I hereby authorize my insurance benefits to be paid to Wendell Robertson, DDS. I am responsible for services and balances not covered.
I authorize the release of any dental/medical information necessary to process my claim or determine my treatment.

Please Initial: _____

What brings you into our office today?

_____

_____

_____

I hereby certify that I have accurately and honestly filled out this form to the best of my knowledge and I accept and agree to all of the policies of this office.

Signature: _____ **Date:** _____

(Patient, parent, or guardian)