

# WELCOME TO PROFESSIONAL DRIVE DENTAL GROUP

---

From whom did you hear about our office? \_\_\_\_\_

May we mention your name when thanking them? \_\_\_\_\_

**NAME:** \_\_\_\_\_ Name preferred: \_\_\_\_\_ Sex:  M  F

Birthdate: \_\_\_/\_\_\_/\_\_\_ Marital Status:  S  M  D  W Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_ Work phone: \_\_\_\_\_

**SPOUSE:** \_\_\_\_\_ Birthday: \_\_\_/\_\_\_/\_\_\_ Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_ Work phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## **IF PATIENT IS A CHILD/DEPENDENT**

Parent/Guardian: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Cell phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_ Work phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_ Work phone: \_\_\_\_\_

## **INSURANCE INFORMATION**

Dental Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Employer: \_\_\_\_\_

**ASSIGNMENT & RELEASE:** I hereby authorize my insurance benefit payments to be assigned directly to Professional Drive Dental. I also authorize the dentist to release any information required for the insurance claim.

**FINANCIAL AGREEMENT:** By signing I understand and accept that payment in full is due at the time of service, unless discussed and accepted by this office prior to services being provided. If there is dental insurance we will **estimate** any co-payments or payments that will be due at the time of service. This is **NOT** a guarantee of benefits. Because of the number of patients and insurance plans, we are unable to know the specifics of your plan. We encourage you to become familiar with your own plan. You are responsible for any balances that remain on your account if the insurance does not pay as much as anticipated or they deny payment.

I have received Professional Drive Dental's Notice of Privacy Practices.

**THANK YOU** for choosing PROFESSIONAL DRIVE DENTAL GROUP. Our goal is to offer you the best possible dental care and understanding of the dental treatment recommended to you.

**SIGNATURE:** (Parent/Guardian if Child/Dependent): \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_