

**Patient Information:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_ Sex:  Female  Male

Marital Status:  Single  Married  Divorced  Separated  Widowed  Domestic Partner

E-Mail Address: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Check preferred contact number:

Home: \_\_\_\_\_  Work: \_\_\_\_\_ Ext: \_\_\_\_\_  Cell: \_\_\_\_\_

Student Status:  Full Time  Part Time School Name: \_\_\_\_\_ City & State: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Not Covered by Dental Insurance – Self Pay**

**Insurance Information:** (If patient is the insurance policy holder, duplicate information fields may be skipped)

**Primary** Dental Insurance Company: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber of Insurance: \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SS #: \_\_\_\_\_ Alternate ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

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**Secondary** Dental Insurance Company: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber of Insurance: \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SS #: \_\_\_\_\_ Alternate ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Referrals:** We would love to know how you were referred to us:  Sudbury Dental Arts Website  Insurance Company/Website  
 Phonebook  Mailer/Postcard  Driving By/Window  Patient or Provider: \_\_\_\_\_

**Acknowledgements:**

**Insurance Assignment & Release:** I certify that I and/or my dependents have insurance coverage as specified above and assign Sudbury Dental Arts all insurance benefits, if any, otherwise payable to me for services rendered. Sudbury Dental Arts may use and disclose my health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

**Receipt of Notice of Privacy Practices:** I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

I, \_\_\_\_\_, have provided accurate information to the best of my ability.

**Print Patient Name**

\_\_\_\_\_

**Signature of Patient/Guardian** **Date**