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**2431 Easton Avenue, Bethlehem, PA 18017 (610)861-0190**

**1050 S. Cedar Crest Blvd. Suite 104, Allentown, PA 18103 (610)973-2090**

***ADULT PATIENT INFORMATION***

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_ F\_\_ Date of Birth\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_

Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_Zip\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_Spouse Social Sec#\_\_\_\_\_\_\_\_\_\_

Spouse Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU FIND US?

Google\_\_ Office Website\_\_ Insurance Website\_\_ Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Seen\_\_\_\_\_\_\_\_\_\_

Former Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dental Insurance Information***

**Primary Insurance**

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Soc Sec OR ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_

***Secondary Insurance***

 Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID or Soc. Sec. \_\_\_\_\_\_\_\_\_\_\_#Date of Birth\_\_\_\_\_\_\_\_\_

PERMISSION IS HEREBY GRANTED TO THE DOCTOR TO PERFORM ANY NECESSARY DENTAL WORK. I ACKNOWLEGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT. I UNDERSTAND THAT FILING A CLAIM WITH MY INSURANCE DOES NOT RELIEVE ME FROM MY RESPONSIBILITY FOR THE PAYMENT OF ALL CHARGES. I CERTIFY ALL THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THE INFORMATION PROVIDED ABOVE.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGN AND PROCEED TO NEXT PAGE