BECK DENTAL CARE

Patient Information

Patient Name____Preferred Name ______________
Last First MI

Gender(male/female) Check Appropriate Box: ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated

Birth Date: ______________ Soc.Sec#_________________________

Email Address____

Address: ____
Street City State Zip

Phone #'s: Home____________________ Work__________________ Cell____________ Best time to call________

Referral information

Whom may we thank for referring you ____

Spouse or Responsible Party Information

Name: ____ Gender: (M/F)
Last First MI

Birthdate:__________________Soc.Sec.#_________________________

Address: ____
Street City State Zip

Phone #'s: Home_______________________ Work_____________________ Cell____________________

Employer ____
Name Address City State Zip

Employment Information

Employer Name:__________________________________ Employer #____________________________

Address: ____
Street City State Zip

Insurance Information

Name of Insured____
Last First MI

Insured's Birthdate: __________________ ID#__________________________ Group #_________________

Employer ____

Patient relationship to insured: ☐ self ☐ Spouse ☐ Child ☐ Other ______________________

Insurance Plan Name and Address: ____

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Secondary

Name of Insured____
Last First MI

Insured's Birthdate: ________________ ID#__________________________ Group #____________

Employer ____

Patient relationship to insured: ☐ self ☐ Spouse ☐ Child ☐ Other ______________________

Insurance Plan Name and Address: ____

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I will be paying today by: ☐ Cash ☐Check ☐Credit Card ☐Care Credit

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all costs of collection of this account, including reasonable attorney fees. I have read all the information on this sheet and have completed all the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

____ ______________________

Signature of Patient or Guardian **Date**