Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ *Birthdate* _____ *Soc. Sec.#*_____

*Person Responsible Employed by*_____*Phone#* _____

Insurance company _____ *Phone#* _____

*Group #*_____*Subscriber #*_____*# of dependents under plan*_____

Dental History

1. How long since you're last dental visits? _____
2. Have you had Periodontal (Gum) treatments? _____
3. Do your gums bleed, or feel tender or irritated? _____
4. Are you having dental problems now? _____
5. Does your jaw click or pop? _____
6. Have you had braces? _____
7. When was your last full set of x-rays? _____
8. Do you like your smile? _____

Authorization

I authorize you to make inquires you consider necessary (including requesting reports from consumer reporting agencies and other sources) in evaluating my application, and subsequently, for purpose of reviewing, maintaining or collecting my account. I also understand that Care Credit will govern my account.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the dentist to help determine appropriate and healthful dental treatment will use this information. If there is any change in my medical status, I will inform the dentist.

I Authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ *Date* _____