Soundental
ASSOCIATES, PC

Our practice will provide the highest quality and comprehensive oral healthcare to our patients. With respect and integrity, we strive to fully satisfy our patients.

PATIENT INFORMATION (please print)

Date _____ How did you hear about our dental practice?_____

First Name_____ Preferred Name_____ Last Name_____

Address_____ City_____ State/Zip_____

Email_____ Cell # (_____)_____

Home Phone (_____)_____ Work Phone (_____)_____

Preferred methods of communication for appointment reminders and scheduling?

E-Mail □ Cell phone □ Text Message □ Home Phone □ Other □_____

Date of birth_____ Gender Male □ Female □

Marital Status_____ Spouse's name (if applicable) _____

Employer _____ Employer phone number (_____)_____

Employer Address_____ Occupation_____

Person responsible for payment? _____

INSURANCE and/or GUARDIAN INFORMATION

Policy Holder Name (Last, First) _____

Relationship to Patient_____ Date of birth _____

If minor, does child live with mother, father, or guardian?_____

Policy Holder Information (if different than above)

Address_____ City_____ State/Zip_____

Email_____ Cell # (_____)_____

Home Phone (_____)_____ Work Phone (_____)_____

Primary Insurance Information

Name of Insured _____

Insured Date of Birth _____

Employer _____

Dental Insurance Company _____

Address_____

Subscriber #_____ Group #_____

Relationship to patient: Self □ Spouse □ Child □ Other □

Secondary Insurance Information

Name of Insured _____

Insured Date of Birth _____

Employer _____

Dental Insurance Company _____

Address_____

Subscriber #_____ Group #_____

Relationship to patient: Self □ Spouse □ Child □ Other □

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance Company(ies)
directly to Soundental Associates, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Payment for services are due at the time of treatment unless other arrangements have been made in advance. Soundental Associates, PC may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Please print name Relationship to patient