

WELCOME

TO WILLIS DENTAL PRACTICE



Please take a few minutes to answer the following questions so we can better assist you with your health care needs

PATIENT INFORMATION

Today's Date _____ Birth date ____/____/____ Patient Social Security# _____

Patient Name _____
(Last Name) (First Name) (initial)

Address _____

City _____ State _____ Zip _____

Occupation _____ Male Female Single Married Widowed Divorced Separated

Patient Home Phone _____ Patient Work Phone _____

Employer _____ Employer Phone _____

Employer Address _____

In Case of Emergency Contact:
Name _____ Relationship _____

Emergency Phone Number _____

PRIMARY INSURANCE

Individual responsible for this account _____
(Last Name) (First Name) (initial)

Relation to Patient _____ Birth date ____/____/____ SS# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance company Address _____

Subscriber ID# _____ Group # _____

ADDITIONAL INSURANCE

Insured Individuals Name _____
(Last Name) (First Name) (initial)

Relationship to Patient _____ Birth Date _____ SS# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured party Employed By _____ Business Phone _____

Insurance Company _____

Insurance company Address _____

Subscriber ID# _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to office Dr. _____ all insurance benefits, for any services provide me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for relates services. I agree to pay for all charges not covered by a third party payer. I Authorize a copy of this authorization to be used in place of the original. In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here. I expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted.

Signature _____ Date _____