Welcome Information

In order to serve you properly, we will need the following
All information will be kept confidential

PERSONAL

Name ____
Last First MI (Preferred)

Birthdate __________ SS#____________ Gender: M ___ F___ Married: Y___ N___

How did you hear about us? ____

(If someone referred you here, please write down their name so we can thank them.)

CONTACT INFORMATION

Address ____

City ___________________________ State ______ Zip _______________

Home # ______________ Cell # _________________Work # _____________________

Email _______________________ Preferred Contact Method _____________________

Emergency Contact _______________________ Contact Phone # _____________

INSURANCE POLICY 1

Relationship to Subscriber: Self ____ Spouse _____ Child _____

Subscribers: Name ________________ ID # _______________ DOB: ____/____/____

Insurance Company ______________________ Phone # ____________________

Employer Name ___________________ Group # __________________________

INSURANCE POLICY 2

Relationship to Subscriber: Self ____ Spouse ____ Child ____

Subscribers: Name ________________ ID # ______________ DOB ____/____/____

Insurance Company ______________________ Phone # ____________________

Employer Name ___________________ Group # __________________________

PAYMENT

Payment or verification of insurance coverage is required at time of treatment. For payment of fees for paying your portion of fees not covered by insurance, we accept the following payment options:

Cash ____ **Check** ____ **MasterCard** ____ **Visa** ____ **American Express** ____ **Discover** ____ **Care Credit** ____

I hereby authorize my insurance benefits to be paid directly to Jacqueline Bennett DDS, PLC and I authorize the doctor to release any information to process insurance claims.

Date ________________ Signature ____

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