SOUTH MOUNTAIN FAMILY DENTAL

2233 W. Baseline Rd Suite #104 Tempe, AZ 85283 (602) 438-9245

Dental Registration and Treatment

Date_____

Patient Information

Patient Name _____
Date of Birth_____
Social Security #_____
Address_____
City _____Zip_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Employer/School_____

☐ Full Time ☐ Part Time ☐ Male ☐ Female

Best time to contact you?

What is the best time of the day to reach you?

_____

Email_____

How did you hear about Impressions Dental?

☐ Personal Referral_____

☐ Mailing ☐ Phone Book_____

☐ Newspaper Ad ☐ Building Sign ☐ Insurance

☐ Website ☐ Other_____

Primary Dental Insurance

Subscriber Name _____

Relationship to patient_____

Subscriber's Date of Birth_____

Subscriber's SS/ID#_____

Address (if different from patient) _____

Subscriber's Employer_____

Insurance Company _____

Group #_____

Secondary Dental Insurance

Subscriber Name _____

Relationship to patient_____

Subscriber's Date of Birth_____

Subscriber's SS/ID#_____

Address (if different from patient) _____

_____

Subscriber's Employer_____

Insurance Company _____

Group #_____

Assignment and Release

If you have Dental Insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage with _____and assign
Name of Insurance Company
directly to South Mountain Family Dental and its associates 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.

South Mountain Family Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

_____
Signature of patient or personal representative

_____
Print name of patient or personal representative

_____ _____
Date Relationship to Patient

Contact Information

Phone: Home _____ Cellular_____ Work _____
May we call your work to reach you? Yes No

EMERGENCY CONTACT INFORMATION

Name: _____Relation_____Cellular_____