Tracy Dental Excellence

Patient Information (confidential)

Name | DOB | Home Phone

Address | City | State | Zip

Email | Cell Phone

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for referring you?

Person to contact in case of emergency | Phone

Responsible Party

Relationship to Patient:

Name of person Responsible for this Account if not self

Insurance Information

Relationship to Patient:

Name of Insured

DOB | SS#

Name of Employer | Union/Local#

Address of Employer | Work Phone

Insurance Company | Group# | Policy/ID#

Ins Co Address | City | State | Zip

Do you have additional Insurance?

2nd Insurance Information

Relationship to Patient:

Name of Insured

DOB | SS#

Name of Employer | Union/Local#

Address of Employer | Work Phone

Insurance Company | Group# | Policy/ID#

Ins Co Address | City | State | Zip

Release:

I authorize the Dentist to perform diagnostic procedures and necessary treatment for proper dental care. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administration of insurance claims benefits and/or to be provided to another Dentist. I hereby authorize payment of insurance benefits directly to the Dentist. I understand that my dental insurance carrier, or payor of my dental benefits, may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts.

Patient/Guardian Signature | Date