

PATIENT INFORMATION

Patient's Name: _____ **Date of birth:** _____ **Sex:** _____
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone #:(** _____ **)** _____
Work #: _____ **Cell#:** _____ **E-Mail:** _____
Social Security #: _____ **Referred by:** _____

Patient's Employer: _____ **Occupation:** _____

PRIMARY INSURANCE INFORMATION

Name of Subscriber on ins. plan : _____ **DOB:** _____
What is the patient's relationship to the insured? _____
Insurance ID # of the person insured: _____
Address of the person insured:(if different than patient's) _____
Employer's name and address: _____
Group # or name: _____
Insurance Company's Name and Address: _____

SECONDARY INSURANCE INFORMATION

Name of Person Insured: _____ **DOB:** _____
What is the patient's relationship to the insured? _____
Insurance ID # of the person insured: _____
Address of the person insured:(if different than patient's) _____
Employer's name and Address : _____
Group # or name: _____
Insurance Company's Name and Address: _____

Name of person responsible for payment: _____

*IF FOR ANY REASON THE ESTIMATED AMOUNT IS NOT PAID BY YOUR INSURANCE COMPANY, IT BECOMES YOUR OBLIGATION.**

I understand that I am financially responsible to Connecticut Family Dentistry for the charges incurred for dental services performed. I agree that in the event my balance shall be more than thirty (30) days past due, I will pay a finance charge of 1% of such unpaid balance, such finance charge to be not less than \$1.00. I further agree that in the event of non-payment of such balance, I shall pay the costs and fees of collection, including a reasonable attorney's fee, should this be necessary. I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.

Signature of Patient, Parent or Guardian: _____ **Date:** _____