BOWERS & OKI
FAMILY DENTISTRY

Thank you for visiting Bowers and Oki Family Dentistry. We are pleased to have you join our practice and want your visit to be as pleasant and comfortable as possible. Please help us by completing this confidential form. If you have any questions or need assistance, please ask, we are happy to help.

Patient Information

Name_____
LAST NAME FIRST NAME MIDDLE INITIAL PREFERRED NAME

Address_____

_____

Home Phone_____ Cell_____ E-mail_____

I would like to receive (check all that apply): E-mail reminder/newsletters ____ Text message reminders ____

Birth Date_____ Age_____ Gender_____ Social Security #_____-_____-_____

Please Circle One: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Employer_____Occupation_____

Address_____ Phone #_____ext_____

Spouse or Parent/Guardians Name_____ Employer_____ Phone_____

Who may we thank for referring you?_____

Emergency contact_____ Phone_____ Relationship_____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Address_____ Phone_____

Drivers license #_____ Birth Date_____ SS#_____-_____-_____

Employer_____ Phone #_____

Insurance

Primary Dental Carrier

Subscriber Name_____ Social Security #_____

Subscribers relationship to Patient_____ Subscriber's Birth Date_____

Employer_____ Employer's Address_____

Insurance Company_____ Group #_____

Insurance Co Address_____ Insurance Co Phone #_____

Secondary Dental Carrier

Subscriber Name_____ Social Security #_____

Subscribers relationship to Patient_____ Subscriber's Birth Date_____

Employer_____ Employer's Address_____

Insurance Company_____ Group #_____

Insurance Co Address_____ Insurance Co Phone #_____

I certify that the above information is correct to the best of my knowledge. I hereby authorize payment directly to Bowers and Oki Family Dentistry all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of all services rendered regardless of insurance payment. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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Signature_____ Date_____