

Freeman Family Dentistry  
 500 N. Eastern  
 Moore, OK 73160  
 (405)912-3300

<u>Patient Information</u>	<u>Dental Insurance</u>
Date: _____ SS#/HIC/Patient ID#: _____	Who is responsible for this account? _____
Patient Name _____	Relationship to Patient _____
Address _____	Insurance Co. _____
City _____ State _____ Zip _____	Group # _____
Sex _____ Age _____ Birth date _____	Is patient covered by additional insurance? Yes ___ No ___
Marital Status _____ Adult _____ Minor _____	Subscriber's Name _____
Patient Employer/School _____	Birth date _____ SS# _____
Occupation _____	Relationship to Patient _____
Employer/School Phone _____	Insurance Co. _____
Spouse's name _____	Group # _____
Birth date _____ SS# _____	
Spouse's Employer _____	
Who may we thank for referring you? _____	

**Phone Numbers**

Home( ) \_\_\_\_\_ Work( ) \_\_\_\_\_ Cell phone #1( ) \_\_\_\_\_ Cell phone#2( ) \_\_\_\_\_

Spouse's Work( ) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

Email \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT(Specify someone who does not live in your household)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Print above signed name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_