PATIENT INFORMATION

VIBE DENTAL

PATIENT INFORMATION

Full Name: _____
Date of Birth _____ Sex:_____
SS #: _____
Address: _____
_____
Contact #:_____
E-mail: _____
Preferred Contact Method: _____

Employer: _____
Employer's Phone #: _____
Whom may we thank for referring you?
_____

RESPONSIBLE PARTY INFORMATION

Name: _____
Date of Birth:_____
SS#: _____
Address: _____
_____

EMERGENCY CONTACT INFORMATION

Name: _____
Phone: _____

PREFERRED PHARMACY

_____

INSURANCE INFORMATION

Please present your insurance card so that we can keep a copy in your patient record.

PRIMARY DENTAL INSURANCE

Company Name: _____
Group# (Plan, Local, Policy #): _____
Insured's Name: _____
Relationship to Patient: _____
Insured's Address: _____
_____
Insured DOB: _____
Insured's SS#: _____
Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____
Group# (Plan, Local, Policy #): _____
Insured's Name: _____
Relationship to Patient: _____
Insured's Address: _____
_____
Insured DOB: _____
Insured's SS#: _____
Insured's Employer: _____

I hereby authorize that for the time Vibe Dental keeps this document on file, they may use it to represent my consent in filling for insurance payment of any dental procedures performed.

Payment of the group insurance benefits otherwise payable to me will be made directly to Vibe Dental.

I am responsible for prompt payment of the account including the balance not covered by insurance. I agree to pay amounts and charges incurred by myself and members of my family for services rendered. Failure to make pay- ment when requested or agreed is basis for legal action and I agree to pay all costs of collection, including any attorney's fee.

Patient Signature_____ Date_____