

**Patient Information:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
ID # \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ e-mail \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Referred By \_\_\_\_\_

In case of emergency, Please contact \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible party information, if different from patient:**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ID # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Insurance Information:**

(This office offers the courtesy of Insurance Billing, however we are not a preferred provider for any insurance companies)

**Primary Insurance:** Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Customer Service Phone \_\_\_\_\_  
Social Security & ID # \_\_\_\_\_ Group No. \_\_\_\_\_

**Secondary Insurance:** Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Customer Service Phone \_\_\_\_\_  
Social Security & ID # \_\_\_\_\_ Group No. \_\_\_\_\_

I authorize my insurance benefits to be paid directly to J. Sam Sage, DDS PLLC for services rendered and to release any information requested by the insurance company with regards to payment of benefits.

Your insurance policy is a contract between you and your insurance company. Since insurance policies vary, even within the same company you need to keep track of your plans allowed benefits and maximums. All questions about your coverage should be directed to your insurance company or your company representative. As the patient and/or above mentioned responsible party, it is your responsibility to know your insurance and verify that you have coverage for the dental services you seek. Your insurance company has the final say on what is covered and not covered under your policy. If the services are not covered by your insurance, you or the responsible party is ultimately responsible for the cost of these services.

\_\_\_\_\_  
Signature of Patient/Legal Guardian Date \_\_\_\_\_

