Queen Anne
HILLTOP
DENTAL

PATIENT INFORMATION

Welcome to our office. Please provide the following information. It is important to our records and your health.
Note: we ask for Social Security information because many insurance companies track patients with this number.

Patient name (Mr./Mrs./Ms/Dr.) _____
Today's Date ____/____/_____Email Address: _____
Date of Birth: ____/____/____ SSN:_____
Home/Mailing Address: _____
City: _____State:_____ Zip Code: _____
Home Phone: _____ Work/Cell Phone:_____
Occupation(s): _____Employer:_____

How did you find out about us?: Ad(list) _____ Friend(whom)_ _____ Our Website_____
Delta Dental _____ Google_____ Yelp_____SPU Ad_____Other (list)_____

Person Responsible for payment of account (if other than self):_____

☐ **NO INSURANCE**

INSURANCE – PRIMARY COVERAGE
Employee Name_____
Employee SocSec # _____
Employee Date of Birth ____/____/____
Employer _____
Insurance Co. _____
Address_____
Phone _____
Group or Policy # _____

INSURANCE- SECONDARY COVERAGE
Employee Name_____
Employee SocSec #_____
Employee Date of Birth ____/____/____
Employer _____
Insurance Co. _____
Address_____
Phone _____
Group or Policy #_____

Insurance reimbursement is a contract between you and your insurance company. Please read and review our insurance consent form carefully.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit term and policy. Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for the claim.

Signed: _____
Parent (or Guardian) Signature _____ ***Date:*** _____