**Patient Name**: ______________________________ Preferred Name:________________________
Birth Date: ________________ Age: ________ SSN: ________________ Sex: M/F
Marital Status: Married/Single/Widowed/Divorced/Child Email Address:______________________
Mailing Address: ____________________________________________________________________
City: ____________________________ State:______ Zip Code:___________________________
Home Phone: __________________________ Cell Phone: _________________________________
Employer: ___________________________________ Work Phone: ______________________

**Spouse/Parent**: ___________________________ SSN: ________________ Birth Date: ________
Employer: __________________________ Work Phone: _______________________________________

**Emergency contact person**:_______________________________ Phone: _________________
Address: ___________________________ Relationship to Patient: __________________________

Whom may we thank for referring you? _________________________________________________

***Dental Insurance Information***

Please remember that insurance is considered a method of reimbursing the patient fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. As a courtesy we extend to our patients we will file your insurance claims. However all charges are your responsibility from the date services are rendered.

**Primary Insurance** (Please give receptionist your card to copy)

Policy Holder: ______________________________________ Birth Date:_______________________
SSN: ____________________________ Relationship to patient: _________________________
Employer: _______________________________________________________________________
Insurance Company Name: ________________________________ Policy ID#:______________
Group#: _______________________________________ Phone number: _____________________
Claims Address: _________________________________________________________________

**Assignment of Insurance Benefits**: I hereby authorize my insurance benefits to be paid directly to *Silver Creek Dental P.C*. I am responsible for all services not covered. I authorize the release of any dental information and/or x-rays necessary to process any claim.
****Signature***:______________________________________________ Date:___________________
(Patient, legal guardian or authorized agent of Patient)