WELCOME TO KINGSTOWNE DENTAL CARE., PC.

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

PLEASE COMPLETE IN INK ONLY.

Date_____

Patient Information

Name _____ Birth Date_____Age_____ ☐ **Male** ☐ **Female**

Address _____ City, State, Zip_____

Soc. Sec. No. _____ Driver's License #_____

☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Home phone No. _____ Work phone _____ Cell phone_____

email address:_____

Employer _____

Occupation_____Business Address (Street, City, State, Zip) _____

Circle Responsible Party : Same as above Parent Guardian Other_____

Who is responsible for the account?

Name_____Relationship to patient _____ Birth Date _____ Age_____

Driver's License # _____Soc. Sec. #_____

Address_____City, State, Zip _____

Home phone No. _____ Work phone _____ Cell phone_____

Email address _____

Employer _____Occupation_____Address (Street, City, State, Zip) _____

In the event of an emergency, who should we contact? _____ **Relationship** _____ **Phone No.** _____

Dental Insurance Information (Primary Insurance):

Insurance Company_____

Insurance Address_____City, State, Zip _____

Insurance Phone No. _____

Subscriber Name_____Relationship to patient _____

Subscriber information if different from Patient information/Responsible Party:

Address (Street, City, State, Zip) _____Phone number:_____

Subscriber Birth Date _____Soc. Sec. No. _____Member Number _____

Group Number _____ Employer Name _____

Dental Insurance Information (Secondary Insurance):

Insurance Company_____

Insurance Address_____City, State, Zip _____

Insurance Phone No. _____

Subscriber information if different from Patient information/Responsible Party:

Subscriber Name_____Relationship to patient _____

Address (Street, City, State, Zip) _____Phone number:_____

Subscriber Birth Date _____Soc. Sec. No. _____Member Number _____

Authorization and Release:

I authorize the dentist to release any information including the diagnosis and the records to any treatment or examination and rendered to me or my child during the period of such dental care to third party payers and/or other health care providers. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services.

X_____

Signature of Patient or Parent if minor **Date:**