

Date: _____

Patient Information

Name (Last, First): _____ **Date of Birth:** _____
Street Address: _____ **Social Security #:** _____
City State Zip: _____ **Home Phone:** _____
E-Mail Address: _____ **2nd Phone:** _____

Sex: Male Female **Marital Status:** Married Single Widowed Divorced Separated

Employer/School Name: _____ **Occupation:** _____
Employer Address: _____ **Phone #:** _____
City State Zip: _____

Spouse Information

Name (Last, First): _____ **Date of Birth:** _____
Employer Name: _____ **Social Security #:** _____
City State Zip: _____ **Phone #:** _____

Dental Insurance Information (Primary)

Insurance Name: _____ **Address:** _____
ID#: _____ **Group #:** _____ **Plan Name or #:** _____
Name of Insured: _____ **Date of Birth:** _____ **Social Security #:** _____
Insured's Relationship to Patient: Self Spouse Child Other

Dental Insurance Information (Secondary)

Insurance Name: _____ **Address:** _____
ID#: _____ **Group #:** _____ **Plan Name or #:** _____
Name of Insured: _____ **Date of Birth:** _____ **Social Security #:** _____
Insured's Relationship to Patient: Self Spouse Child Other

Emergency Information (Specify someone who does not live in your household)

Contact Name: _____ **Relationship:** _____ **Phone:** _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with (state name of insurance company(ies) _____ and assign directly to Dr. Shikha Batra all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ Signature of Patient, Parent or Guardian	_____ Please print name of Patient, Parent or Guardian	_____ Relationship	_____ Date
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