

Date: _____

Patient Information			
Name (Last, First): _____		Date of Birth: _____	
Street Address: _____		Social Security #: _____	
City State Zip: _____		Home Phone: _____	
E-Mail Address: _____		2 nd Phone: _____	
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>		
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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
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