Patient Information

Full Name _____
Last First Middle Preferred Name

Marital Status _____ Date of Birth _____ Age _____ Soc. Sec. # _____

Residence _____
Street City State Zip Code

Mailing Address _____
Street City State Zip Code

Email Address _____ May we send information to your email address? Yes ☐ No ☐

Home # _____ Work # _____ Cell # _____ May we call at work? Yes ☐ No ☐

Last dentist consulted _____ Referred to us by _____

In case of emergency, name & phone of person to be contacted _____

Responsible Party Information (this section to be completed if patient is not responsible for payment)

Name _____

Mailing Address _____
Street City State Zip Code

How long at this address? _____ Home #: _____ Work #: _____ May we call at work? ☐ Yes ☐ No

Previous address (if less than 3 yrs.) _____

Soc. Sec. # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ # of years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ # of years employed _____

Soc. Sec. # _____ Date of Birth _____ Work #: _____ May we call at work? Yes ☐ No

Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group # _____ Date of Birth _____

Insurance Co. Address _____ Phone # _____

Insured's Employer _____ Insured's ID # _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group # _____ Date of Birth _____

Insurance Co. Address _____ Phone # _____

Insured's Employer _____ Insured's ID # _____

HARVARD DENTAL GROUP

Release of benefits & information I authorize my insurance benefits to be paid directly to Harvard Dental Group. I am financially responsible for any balance due. I authorize Harvard Dental Group or the insurance company to release any information required for this claim. I understand that, where appropriate, credit bureau reports may be obtained. Even though an insurance claim is pending, I will receive a statement each month if my account has an outstanding balance. We will be happy to file your insurance claim, however, we cannot accept responsibility for collecting your insurance claim. The responsible party is obligated for payment in full on this account. In the event of non-payment, responsible party shall bear the cost of collection including, but not limited to, reasonable attorney's fees.

✗ *Signature*_____ *Date* _____

HARVARD DENTAL GROUP