



## The Grand Prairie Dentist Implants & Braces

### PATIENT INFORMATION

Name \_\_\_\_\_  
*Last First M.I. Preferred Name*

Gender: M F Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Driver's License#: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Patient Address \_\_\_\_\_  
*Street City State Zip*

Home Phone #: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Other: \_\_\_\_\_

Which is best for confirmation? E-MAIL \_\_\_\_\_ Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

Emergency Contact : \_\_\_\_\_  
*Name Phone #*

### RESPONSIBLE PARTY INFORMATION (If Different From Above)

Name \_\_\_\_\_  
*Last First M.I. Preferred Name*

Gender: M F Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Patient Address \_\_\_\_\_  
*Street City State Zip*

Home Phone #: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ Other: \_\_\_\_\_

Dental Insurance (If any)  
Insurance Company \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber's Name : \_\_\_\_\_ DOB: \_\_\_\_\_

SSN or I.D.# \_\_\_\_\_ Relationship to Patient : \_\_\_\_\_

Subscriber's Employer : \_\_\_\_\_ Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent( s) have insurance coverage with \_\_\_\_\_ and assign directly to The Grand Prairie Dentist -Implants and Braces and its affiliates all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not they are paid for by insurance. I authorize the use of my signature on all insurance submissions. Please be advised that due to nature of our business, we require a 48-hour cancellation notice. The above named office and /or doctor may use my health care information and may disclose such information to the above named insurance and company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and balance is paid-in-full or two years from the date signed below.

\_\_\_\_\_  
Signature of Patient/Parent or Guardian

\_\_\_\_\_  
Please print name of Patient/ Parent or Guardian

\_\_\_\_\_  
Date