(Please Fill Out Front and Back)

PATIENT INFORMATION (*CONFIDENTIAL*)		
Name (Mr., Mrs., Dr.) First:	Middle Initial:	Last:
Birth Date:	____Male ____Female	SS#
Preferred to be called:		
Home Address:		
City:	State:	ZIP Code:
Do you wish to be contacted for your appointments by email, call, or text? ____Email ____Text ____Call		
Email Address:		
Home Phone:	Work Phone:	Cell Phone:
RESPONSIBLE PARTY (*FINANCIAL*)		
Name:		
Relationship:		
Address:		
City:	State:	ZIP Code:
Home Phone:	Work Phone:	Cell Phone:
EMERGENCY CONTACT INFORMATION		
Name of Person to reach in case of emergency:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
PRIMARY DENTAL INSURANCE		
Insurance Co. Name:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Insurance Co. Phone:		
Insured's Name:		
Subscriber ID:	Group Policy #:	Relationship:
Insured's Birth Date:	Insured's Employer:	
Insured's SS#:		
SECONDARY DENTAL INSURANCE		
Insurance Co. Name:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Insurance Co. Phone:		
Insured's Name:		
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
BILLING CONSENT		
I understand that ASK Dental Care will bill my insurance on my behalf as a courtesy. It remains my responsibility to know how my insurance works and what my benefits are. I understand that ASK Dental Care has no direct relation with my insurance company. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's. I understand all co-pays and patient's portion are due at the time of service.		
SIGNATURE:		DATE: