ARTISAN DENTAL
Cosmetic, Sedation and Implant Dentistry

Patient Information

Patient Name: _____ Date:_____
Last First MI

Gender (circle one): Male Female Other Marital Status (circle one): Married Single Other _____

Social Security #: _ _ _- _ _ - _ _ _ _ Birth Date: _ _- _ _ - _ _ DL#_____ Issuing State _____

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____

Email address: _____ May we contact you by email? ☐Yes ☐No

Address: _____
Street Unit or Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?

☐Another Patient ☐Brochure ☐ZocDoc ☐Another Practice ☐Yelp ☐Google ☐Other

Name of person or office referring you to our practice:_____

Employment Information

The following is for: the patient or the person responsible for payment

Employer Name: _____Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

We will assist in your insurance processing

Primary

Name of Insured: _____ is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Social Security #: _____-_____-_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name:_____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other_____

Insurance Plan Name and Address: _____

Consent for Services

Payments for dental treatment are due the time services rendered. In addition to cash and checks, we accept Visa, MasterCard, Discover and AMEX. If you have dental insurance, it is our policy to help you receive the maximum benefits. As a courtesy to you, we will complete a claim form so that you can be reimbursed by your insurance company. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:
Signature of guarantor of payment/responsible party