

**Patient Information:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_ Sex: ☐ Female ☐ Male

Parent/Guardian's Names: \_\_\_\_\_ Alt. Address (if any): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ ☐ I would like to receive correspondences via e-mail.

Check preferred contact number:

☐ Home: \_\_\_\_\_ ☐ Work: \_\_\_\_\_ Ext: \_\_\_\_\_ ☐ Cell: \_\_\_\_\_Student Status: ☐ Full Time ☐ Part Time School Name: \_\_\_\_\_ City & State: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

☐ **Not Covered by Dental Insurance – Self Pay****Insurance Information:** (If patient is the insurance policy holder, duplicate information fields may be skipped)**Primary** Dental Insurance Company: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber of Insurance: \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SS #: \_\_\_\_\_ Alternate ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary** Dental Insurance Company: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber of Insurance: \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber SS #: \_\_\_\_\_ Alternate ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Referrals:** We would love to know how you were referred to us: ☐ Sudbury Dental Arts ☐ Insurance Company/Website☐ Phonebook ☐ Mailer/Postcard ☐ Driving By/Window ☐ Patient or Provider: \_\_\_\_\_**Acknowledgements:**

**Minor / Child Consent:** I am the parent / guardian of \_\_\_\_\_, and there are no court orders in effect that prohibit me from signing this consent. I hereby request and authorize Sudbury Dental Arts to perform necessary dental services for the above named child including but not limited to diagnostic and/or preventative procedures, updating X-rays, administering anesthetics, and other treatment mutually agreed upon by me and as deemed advisable by the dentist. I hereby authorize Sudbury Dental Arts team to proceed with such dental services whether or not I am present at the time treatment is rendered.

**Insurance Assignment / Release:** I certify that the above named patient is covered as my dependent by insurance as specified and assign Sudbury Dental Arts all insurance benefits, if any, otherwise payable to me for services rendered Sudbury Dental Arts may use and disclose health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

**Receipt of Notice of Privacy Practices:** I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

I, \_\_\_\_\_, have provided accurate information to the best of my ability.

**Print Parent/Guardian Name**\_\_\_\_\_  
**Signature of Parent/Guardian**\_\_\_\_\_  
**Date**