welcome

SUMMIT DENTAL GROUP

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. It is important to remember the treatment we are providing is being performed in a dynamic human environment. As a result, there can be no definitive guarantees of success. Although, with the use of proper planning and execution we are confident success may be obtained.

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____

Date _____

Name (Full) _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced Preferred Name _____ ☐ Male ☐ Female

If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party ☐ Same As Above

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____ Driver's License # _____

Employer _____ Work Phone _____ SS# _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ **Group #** _____ **Policy/ID #** _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ **How Much Have You Used?** _____ **Max. Annual Benefit** _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ **Group #** _____ **Policy/ID #** _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ **How Much Have You Used?** _____

Max. Annual Benefit _____

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Additional Questions on Back ➡