PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)		SEX M F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	MARITAL STATUS S M W D SEP
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY, STATE, ZIP				HOME PHONE NO.	
PATIENT'S EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION (IF STUDENT ☐ FULL-TIME ☐ PART-TIME)			HOW LONG EMPLOYED? or YEAR AT SCHOOL	BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP				EXTENSION	
SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NO.			NUMBER OF CHILDREN AND AGES		
SPOUSE'S EMPLOYER	OCCUPATION (IF STUDENT ☐ FULL-TIME ☐ PART-TIME)			HOW LONG EMPLOYED? or YEAR AT SCHOOL	BUSINESS PHONE NO.	
EMPLOYER'S ADDRESS	CITY, STATE, ZIP				EXTENSION	
CLOSE RELATIVE IN CASE OF EMERGENCY (NOT LIVING WITH YOU)	RELATIONSHIP				HOME PHONE NO.	
RELATIVE'S STREET ADDRESS	CITY, STATE, ZIP					

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE, ZIP		HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP		EXTENSION
FATHER'S NAME	STREET ADDRESS, CITY, STATE, ZIP		HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP		EXTENSION

INSURANCE INFORMATION: *IF YOU WANT US TO PROCESS INSURANCE CLAIMS, THIS PORTION MUST BE COMPLETED.*

1ST OR PRIMARY INSURANCE CARRIER	2ND OR SECONDARY INSURANCE CARRIER
EMPLOYER'S ADDRESS	EMPLOYER'S ADDRESS
EMPLOYER'S CITY, STATE	EMPLOYER'S CITY, STATE
EMPLOYEE / SUBSCRIBER NAME	EMPLOYEE / SUBSCRIBER NAME
EMPLOYEE / SUBSCRIBER SOCIAL SECURITY NO.	EMPLOYEE / SUBSCRIBER SOCIAL SECURITY NO.
PATIENT'S RELATIONSHIP EMPLOYEE / SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	PATIENT'S RELATIONSHIP EMPLOYEE / SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
INSURANCE COMPANY NAME _____ ADDRESS _____ GROUP PLAN NAME _____ GROUP PLAN# _____ CERTIFICATE/ POLICY # _____ UNION/ LOCAL # _____ DEDUCTIBLES ☐ YES ☐ NO $ _____ MAXIMUM BENEFIT PER YEAR $ _____	INSURANCE COMPANY NAME _____ ADDRESS _____ GROUP PLAN NAME _____ GROUP PLAN# _____ CERTIFICATE/ POLICY # _____ UNION/ LOCAL # _____ DEDUCTIBLES ☐ YES ☐ NO $ _____ MAXIMUM BENEFIT PER YEAR $ _____

I HEREBY AUTHORIZE RELEASE OF TREATMENT INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.
I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO HILTUNEN AND NASH, P.C.

SIGNED (PATIENT / GUARDIAN) _____ DATE _____ SIGNED (INSURED PERSON) _____ DATE _____

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED.

WE WILL PROVIDE AN ESTIMATE OF NECESSARY DENTAL SERVICES BASED ON INFORMATION FROM OUR INITIAL EXAMINATION AND X-RAYS. AS TREATMENT PROGRESSES, THIS ESTIMATE MAY BE REVISED. THIS ESTIMATE WILL BE HONORED FOR SIX MONTHS.