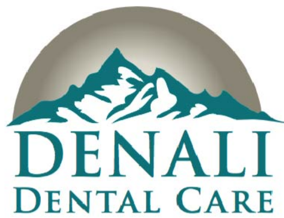

Patient Information Full Name: ___________________________________Date of Birth: ________________
SSN: _____________________ Preferred Name: ____

Single Married Minor Male Female

Contact Information

Address: ____ Email _______________________________

Home Phone ___________________ Cell Phone ____________________Work Phone _________________________

Name of Employer: _______________________________ Address:____

Emergency Contact

Name: ____ Address:____

Phone: ______________________________________ Email:____

Whom may we thank for referring you to our office? ____

Person Responsible for account Patient Guardian Spouse Mother Father

Primary Insurance (Subscriber Information) Relationship to patient:____________________Name:_________________________

Date of Birth: __________________ SSN: ____________________ Address:_____________________________________

Phone:____________ Employer: _________________________ Dental Ins.CO___________________________________

Subscriber ID: ____________________ Group: __________________________ INS Phone__________________________

Secondary Insurance (Subscriber Information)

Relationship to patient: ________________________ Name: ____

Date of Birth: __________________ SSN:___________________Phone:____

Address____

Employer: ____________________________________ Dental Ins. CO____

Subscriber ID: ____________________

Group: __________________________ INS Phone #:__________________________

Assignment of Benefits

I authorize payment directly to the dental office of, Marriner Russell Morrell, DMD, PC, the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize, Marriner Russell Morrell, DMD, PC, to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the dentist the right to release my dental/medical histories and other information about my dental treatment to third party payors and/ or other health professionals by any method including electronic transfer.

Signature of Patient /Parent/Guardian____ **Date** __________________