Antigo Dental Clinic, LLC

SECTION 1

Patient Legal Name (Last, First, M I) | Preferred Name | Social Security No. | Birthdate (M, D, Y) | Sex ☐ M ☐ F

Home Phone | Cell Phone | E-mail address

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Previous/Maiden Name

Mailing Address | Apt. No. | City | State | Zip | County

If PO Box Physical Address

Employer's Name | City | State | Work Phone | **Name of Parents**

Spouse's Name (Last, First, M I) | Employer | City, State | Phone | Name of Children and Ages

Person to Notify in an Emergency | City | State | Phone

Whom do we thank for referring you? | Address | City | State | Phone

Complete Section 2 if patient is under 18 years old or patient is not responsible for services - skip if guarantor is same as patient.

SEC 2

Guarantor's Name (Last, First, M I) | Social Security No. | Birthdate (M, D, Y) | Sex ☐ M ☐ F | Home Phone

Address (Street) | City | State, Zip | County | Previous Name

Employer's Name | City | State | Work Phone

SECTION 3

PRIMARY INSURANCE CO: ☐ Dental Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYEE/POLICY HOLDER (if same as Section 1 above, fill in insurance information only)

Name (Last, First, M I) | Social Security No. | Birthdate (M, D, Y) | Home Phone

Address (Street) | City | State, Zip | **Group/Policy No**

Employer's Name | City, State | Work Phone | **Effective Date**

Insurance Company Name | **Address** | **City State Zip** | **Subscriber ID**

SECONDARY/OTHER CARRIER: ☐ Dental Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMPLOYEE/POLICY HOLDER (if same as Section 1 above, fill in insurance information only)

Name (Last, First, M I) | Social Security No. | Birthdate (M, D, Y) | Home Phone

Address (Street) | City | State, Zip | **Group/Policy No**

Employer's Name | City, State | Work Phone | **Effective Date**

Insurance Company Name | **Address** | **City State Zip**

SECTION 4

AUTHORIZATION FOR RELEASE OF INFORMATION (All patients/guarantors must sign)

I certify that the above information is correct. I authorize Antigo Dental Clinic, LLC to use and release dental, medical or financial information to other parties who have an implicit "right to know" due to my use of their services. This includes insurance companies and state agencies. I understand that no other information related to my treatment or health status will be released without my written consent.

I understand and agree to the terms and conditions of the financial policy described on the reverse side of this form. I agree to pay this account, when due, in accordance with Dental Clinic and State/Federal Agency policies covering the payment of outstanding balances.

Patient/Guarantor Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize the payment of the group insurance benefits otherwise payable to me directly to the Antigo Dental Clinic, LLC.

Policy Holder/Guarantor Signature _____ Date _____

HYGIENE SERVICES

I give permission for a registered dental hygienist to provide services without the dentist present. I understand that a yearly exam by the dentist is needed in order for the hygienist to perform services.

Patient Signature _____ Date _____