Susan Hollinsworth, D.D.S., P.S.

Creating a Healthier World, One Smile at a Time

Patient Information_

Patient's name_____ Date of birth_____
Name to call you _____ __Male __Female Marital status_____
Spouse's name_____
Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____
Email_____
Primary contact number (check one): __Home __Work __Cell __Email Best time to call_____

Employer name & location_____ Occupation_____
(father if minor)
Spouses's employer & location_____Occupation_____
(mother if minor)

Insurance Information

Primary Ins. Co. name_____
Ins. Co. address _____
Ins. Co. phone number_____
Subscriber Name _____
Relationship to patient_____
SS#_____DOB_____
Subscriber ID#_____
Group Number_____

Secondary Ins.Co.name _____
Ins. Co. address_____
Ins.Co. phone number_____
Subscriber Name _____
Relationship to patient_____
SS#_____ DOB_____
Subscriber ID#_____
Group Number _____

Person responsible for account_____ Relationship to patient_____
Person to contact in case of emergency_____ Relationship_____
Home phone_____Cell phone_____Work phone_____

How did you hear about our office?_____
Referred to us by _____Relationship_____
Hobbies/interests_____
Children(siblings) names and ages_____
_____

I understand that I am responsible for payment of services rendered regardless of what my insurance pays. I hereby authorize insurance payments directly to the dental office. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance companies.

Patient's signature_____ **Date** _____