River Place Dental
Changing Lives . . . One Smile At A Time

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient Information Date: _____

First Name:_____ Last Name:_____
Address: _____Address 2:_____
City, State, Zip: _____
Home Phone: _____Work:_____ Ext:_____Cell: _____
Gender: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date:_____Age:_____SSN: _____
Children Living at Home:
Name:_____ DOB:_____ Name:_____ DOB:_____
Name:_____ DOB:_____Name:_____DOB: _____
Name:_____ DOB: _____Name:_____ DOB: _____
If Married Name of Spouse: First Name:_____Last Name:_____
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time
Place of Employment:_____Occupation: _____

Responsible Party (if someone other than the patient)

First Name: _____Last Name:_____
Address: _____Address 2:_____
City, State, Zip: _____
Home Phone:_____Work:_____ Ext:_____Cell: _____
Birth Date:_____Age:_____SSN: _____

Primary Dental Insurance Information

Policy Holders Name:_____Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holders ID Number:_____Policy Holders DOB: _____
Policy Holders SSN:_____
Employer:_____ Insurance Company: _____
Address:_____ Address: _____
Address 2:_____ Address 2: _____
City, State, Zip:_____ City, State, Zip:_____

Secondary Dental Insurance Information

Policy Holder's Name:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holders ID Number:_____Policy Holders DOB: _____
Policy Holders SSN:_____
Employer:_____ Insurance Company: _____
Address:_____ Address: _____
Address 2:_____ Address 2: _____
City, State, Zip:_____ City, State, Zip:_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release any and all necessary information to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Patient, Parent or Guardian Date

Payment is due in full at time of treatment unless prior arrangements have been approved.
(See Reverse Side)

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Patient Disclosure Instructions

I wish to be contacted in the following manner(s) (check all that apply):

- ☐ Home Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Work Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to fax to the following number _____
- ☐ Cell Phone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call back number only
- ☐ Email _____
  - ☐ OK to mail to the email address listed above

I allow you to give my clinical information to or answer questions from (check all that apply and please provide that persons name)

☐ Spouse _____ (Name) ☐ Parent _____ (Name)

☐ Guardian _____ (Name) ☐ Child _____ (Name)

☐ Stepchild _____ (Name) ☐ None

☐ Other (please specify):_____

Patient's Signature: _____ Date: _____

Print Name: _____ Birth Date: _____

Submit