Information About Person to Receive Dental Services (*Please Print*)				
Legal Name: Last		First:		Mid:
Preferred Name (Alias):	Maiden Name:	Date of Birth:	Age:	☐ Male ☐ Female
SSN:	Primary Language: ☐English ☐Spanish ☐Other	Race: ☐Asian ☐Black or African American ☐Native American ☐White ☐More Than One ☐Unknown/not reported Ethnicity: ☐Not Hispanic ☐Hispanic ☐Other ☐Unknown/not reported		
Mailing Address:		Apt. / Lot #		Phone #1:
City:	State:	Zip:		Phone #2:

Parent/Guardian (*if other than self*):

Child Lives With: ☐Mother ☐Father ☐Both Parents ☐Other			
Mother's Name:	Date of Birth:	SSN:	Phone:
Address:			
Father's Name:	Date of Birth:	SSN:	Phone:
Address:			
Guardian/Other Name:	Relationship:	Address/Phone:	

Can we e-mail / text / call to remind you about your appointment? ☐ Yes ☐ No

E-mail address:_____ Cell # for text:_____

Other phone #:_____ Can we leave a message? ☐ Yes ☐ No

Whom can we speak with about your appointment besides you? _____

Emergency Contact:	Address:	Phone:
Physician Name:	Address:	Phone:

DENTAL Insurance: To bill for your services, the clinic MUST have a copy of your insurance card(s). It is your responsibility to bring all cards with you to every visit. **Co-pays are expected at time of service**.

#1 Primary Dental Insurance (Name)			**#2 Other Dental Insurance** (Name)		
ID/Contract # Group #			ID/Contract # Group #		
Cardholder Name	DOB	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other	Cardholder Name	DOB	Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Employer	Insurance Address/Phone		Employer	Insurance Address/Phone	

Assignment of Benefits: I hereby assign all medical and/or surgical benefits be made directly to VanBuren-Cass County District Health Department/Community Dental Clinics on my behalf, for any services provided to me. I authorize any holder of medical and other information about me, to release to Medicare and its agents, any insurance company, any other third party, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits, or benefits for related services.

I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. I certify that the above information is true and correct.

X Signature:_____ **Date:**_____

Patient or Parent/Guardian (if patient is a minor)