Elan Dental Group
Expect Excellence

Patient Information

NAME (Last, First, Middle): _____

PREFERRED NAME (Nickname): _____ ☐Married ☐Single ☐Minor ☐Male ☐Female

SOCIAL SECURITY # _____ STATE DRIVER'S LICENSE #_____

BIRTHDATE: _____ EMAIL: _____

ADDRESS: _____
Street Apt.# City State Zip

TELEPHONE: _____
Home Work Cell

NAME OF EMPLOYER: _____ ADDRESS: _____

IF FULL TIME STUDENT, SCHOOL NAME: _____ GRADE: _____

PERSON RESPONSIBLE FOR ACCOUNT *IF PATIENT IS UNDER 18*: _____

Primary Insurance Information

INSURED NAME: _____ BIRTHDATE: _____

ADDRESS: _____
Street Apt.# City State Zip

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

DENTAL INSURANCE COMPANY: _____ (PLEASE SHOW CARD TO FRONT DESK REPRESENTATIVE)

INSURED'S SS#: _____SUBSCRIBER ID: _____ GROUP #_____

Secondary Insurance Information

INSURED NAME: _____ BIRTHDATE: _____

ADDRESS: _____
Street Apt.# City State Zip

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

DENTAL INSURANCE COMPANY: _____ (PLEASE SHOW CARD TO FRONT DESK REPRESENTATIVE)

INSURED'S SS#: _____SUBSCRIBER ID: _____ GROUP #_____

How did you hear about our office? _____

Person to contact in case of emergency: _____
Name Phone

Preferred Pharmacy: _____
Name Address City/State

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary proper dental care. The information on this page is correct to the best of my knowledge. I understand that it is my responsibility to provide updated information to the Dental Office if/when changes occur. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors by any method, including electronic transfer.

Signature Patient/Responsible Party _____ Date: _____