Medical Alert for Office Use

WOODBRIDGE DENTAL CENTER

Thank you for visiting Woodbridge Dental Center for Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION

DATE:

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL) _____ (NICKNAME)

Address _____ (STREET)

_____ (CITY) _____ (STATE) _____ (ZIP)

Employer _____ E-mail Address _____

Drivers License _____ Occupation _____

Birth Date _____ Height _____ Weight _____

Phone: Home ( ) _____ **Social Security #** _____

Work ( ) _____ May we contact you at work? ❑ Yes ❑ No

Mobile ( ) _____ ❑ Male ❑ Female

Emergency: Name _____ Phone ( ) _____ Relationship: _____

Please Circle: Single Married Divorce Widow Child

INSURANCE

Primary Dental Carrier

Subscriber Name _____ SSN / ID# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ SSN / ID# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

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 and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

IF PATIENT IS UNDER 18

Responsible Party _____ Relation to Patient _____

Address _____ (STREET)

_____ (CITY) _____ (STATE) _____ (ZIP)

Telephone ( ) _____