FOREST DRIVE DENTAL CARE

3731 Forest Drive
Columbia, SC 29204

Patient Information

Name: _____ _____ _____ Preferred Name:_____
Last First Middle

Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Marital Status:_____

SSN:_____-_____-_____ DOB:_____, ___ _____
Month Day Year

Emergency Contact:_____ _____
Name Phone

Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Although we estimate what your insurance company will pay, it is the insurance company that makes the final determination of your benefits. You agree to pay any portion of the charges not covered by insurance. I hereby authorize payment by my insurance companies be directly made to Forest Drive Dental Care. I also authorize the release of any dental information necessary to process my claims. I understand that I am ultimately responsible for all costs associated with treatment provided for me/my family regardless of insurance coverage.

Primary Dental Insurance
Ins. Company Name:_____ Ins. Company Phone:_____
Member/Subscriber ID#:_____ Employer/Group Name:_____ Employer/Group #:_____
Subscriber/Policy Holder Name:_____ Relationship to Patient:_____
DOB:_____ SSN:_____-_____-_____ Place of Employment:_____
Mailing Address:_____ Marital Status:_____

Secondary Dental Insurance
Ins. Company Name:_____ Ins. Company Phone:_____
Member/Subscriber ID#:_____ Employer/Group Name:_____ Employer/Group #:_____
Subscriber/Policy Holder Name:_____ Relationship to Patient:_____
DOB:_____ SSN:_____-_____-_____ Place of Employment:_____
Mailing Address:_____ Marital Status:_____

Primary Medical Insurance
Ins. Company Name:_____ Ins. Company Phone:_____
Member/Subscriber ID#:_____ Employer/Group Name:_____ Employer/Group #:_____
Subscriber/Policy Holder Name:_____ Relationship to Patient:_____
DOB:_____ SSN:_____-_____-_____ Place of Employment:_____
Mailing Address:_____ Marital Status:_____

Secondary Medical Insurance
Ins. Company Name:_____ Ins. Company Phone:_____
Member/Subscriber ID#:_____ Employer/Group Name:_____ Employer/Group #:_____
Subscriber/Policy Holder Name:_____ Relationship to Patient:_____
DOB:_____ SSN:_____-_____-_____ Place of Employment:_____
Mailing Address:_____ Marital Status:_____

Acknowledgement I hereby acknowledge reading and understanding this form in its entirety. The undersigned hereby authorizes the doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I have any change in my health or change in my medication, I will inform the doctor at my next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

_____ _____ _____
Print Name Signature Date