Kindred Oaks
DENTISTRY

Patient Information
(Please Complete In Ink) (Required*)

*Full Name_____ *Date of Birth_____

*Email Address_____ Pharmacy_____

*Address_____ *City_____ *State_____ *Zip Code_____

*Telephone: Home: _____ *Work:_____ *Cell/Mobile:_____

*Social Security #:_____ *Driver's License #:_____

Occupation_____ Employer_____ Marital Status _____

*Emergency Contact Name:_____ *Phone:_____

***Guardian or Responsible Party**

Full Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip Code: _____

*Telephone: Home:_____ *Work:_____ *Cell/Mobile:_____

***Insurance Information**

Name of Insured_____

Date of Birth_____ Social Security_____

Employer_____ Insurance Company_____

Policy #_____ Group #_____ Phone #_____

Do you have additional dental insurance? Yes No If yes, please notify our staff.

We are happy to assist you in understanding and filling your insurance for most dental procedures. Please remember your insurance is a contract between you, your employer, and your insurance company. We require payment of patient's portion at the time of treatment. Our office policy states that you are solely responsible for your bill. If we do not receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

_____ _____ _____
Patient Name (Print) Patient/Parent or Guardian Signature Date