Harte Dental

PATIENT LAST NAME: _____**FIRST:**_____**INITIAL**:_____

How do you wish to be addressed?_____ Date of Birth_____

Primary Insurance	**Secondary Insurance**
Subscriber Name_____	Subscriber Name_____
Subscriber ID_____	Subscriber ID_____
Date of Birth_____	Date of Birth_____
Relationship to Subscriber: Self Spouse Child Other	Relationship to Subscriber: Self Spouse Child Other
Employer Name_____	Employer Name_____
Employer Phone_____	Employer Phone_____
Insurance Company_____	Insurance Company_____
Insurance Group_____	Insurance Group_____
Insurance Phone_____	Insurance Phone_____

INSURANCE INFORMATION

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If minor)

Last name:_____First:_____Initial:_____

Address (if different)_____ Date of Birth_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____(Mobile)_____

EMERGENCY CONTACT

Last Name_____First:_____Initial:_____

Telephone (Mobile Work Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature_____ Date _____

(Responsible Party, if under 18)