



### Patient Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-Mail address \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Phone ( ) \_\_\_\_\_  
Employer Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Referral

How did you hear about us:  Canby Connection  Yellowbook  Web-search  Drive by  
 Canby Herald  Insurance  Current Patient  
Other: \_\_\_\_\_

### Guarantor (If not the same as above)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Relationship \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Employer's Phone ( ) \_\_\_\_\_

### Insurance

	Primary	Secondary
Insurance Co.	_____	_____
Subscriber Name	_____	_____
Subscriber DOB	_____	_____
Subscriber ID	_____	_____
Group Number	_____	_____
Insurance Phone	_____	_____

### Emergency Contacts

#1 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
#2 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I hereby authorize Neal Family Dental to furnish information to insurance companies concerning my dental condition/s and treatment and I hereby authorize the above named insurance company or companies to release payments directly to Neal Family Dental. I understand that I am responsible for all fees regardless of insurance coverage and finance charges will be applied to past due account balances.

I acknowledge that I received and reviewed Neal Family Dental Privacy Policy. I agree to pay for services rendered. I acknowledge that insurance benefits may be incorrect and any and all charges will be my responsibility.

PATIENT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_