Legacy
DENTAL CARE

TELL US ABOUT YOURSELF

*Date:*_____

Name:_____ Preferred Name:_____

Date of Birth: ____/____/____ SSN# : _____

Home Address: _____

City,State & Zip_____

Home#:_____ Work#: _____

Cell#:_____ E-Mail:_____

Do you prefer text/email/phone confirmation_____

Marital Status_____

Spouse's Name:_____ Date of Birth____/___/____

Other family members seen by us?_____

Billing Information/Dental Insurance

Employer:_____ Occupation:_____

Insurance Company's Name:_____

Insurance ID # _____ Group# _____

Policy Holders Name: _____

Date of Birth ____/____/____

Emergency Contact

Name: _____ Relation: _____

Home#: _____ Cell#: _____

I certify that I/my dependents have insurance coverage and assign directly to Legacy Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I authorize release of any information relating to this claim. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature:_____ Date:_____