## RC Dental Group Patient Information

Patient Name: Birth Date							
Parent/G	Guardian Nan	ne:					
		Last	First	MI			
□ Male	□ Female			□ Married	□ Single □ Chi	ild □ Other	
Social S	ecurity #:		*	_ Driver's Licens	e #:	State:	
Address	s:				Apt #:		
City:				State: Zip Code:			
						ell:	
E-Mail: _					Fax:		_
			Emerge	ency Contact Inf	ormation		
Name: _			_	-			
				y Insurance Info			
Name	e of Insured:			Re	lation to patient :	□ Self □ Spouse □ (	Child   □ Other
Insured's	s Birth Date:	Last	First ID#:		Group #	;	181
		Same as Patient o					
			Stree	et	city	state	zip
					-		
Employe	er ivame and	pnone #					6
			Second	dary Insurance (	Coverage		
Name of	f Insured:			Relation	on to patient : □ S	Self □ Spouse □ Chil	d □ Other
1	- Dinth Datas	Last	First		Group #		
		Same as Patient o					
insureu :	S Audress. 🗆	Same as Fallent 0	Stree		city		zip
Insuranc	ce plan name	:			Ph#:		
				Referral Informat	ion		
Mho ma	ov wa thank fo	or referring you to a				er Doctor   Dental C	Office
		fice referring you to do					
raino oi	r porcon or or	noo roronnig you to	от руски	Consent			
release of for insurar authorize p	any information once benefits. I au payment of insuratal benefits may pareview.	concerning my (or my dep uthorize release of any info nce benefits directly to the ay less than the actual bil bus agreements to the cor	endant's) denta ormation conce e dentist or der I for services. ntrary and agre	al care, advice and treeming my (or my dependantal group, otherwise pull understand I am final to be responsible fo	atment provided for the adant's) health care, ac ayable to me. I unders acially responsible for propayment of services no	necessary for proper denta purpose of evaluating and dvice and treatment to anot stand that my dental insurar payments in full of all accou tot paid in whole by my den as matters related to this fo	administering claim her dentist. I hereby nce carrier or payer nts. By signing this tal insurance. I gran
I have re	ead the above	conditions of treatm	nent and pay	ment and agree t	o their content.		
				,			
Signature o	of patient, parent o	r guardian	[	ate	Relation	n to patient	