EMPOWER DENTAL
Rebecca Orsini, D.M.D.

I prefer to be contacted via:
email ( ) phone ( )
home/cell text ( )

WELCOME to EMPOWER DENTAL!

TODAY'S DATE:

PATIENT INFORMATION

FULL NAME: I PREFER TO BE CALLED:			MARITAL STATUS (CIRCLE ONE) SINGLE / MAR / DIV / SEP / WID
DATE OF BIRTH: / /	AGE:	SS#:	GENDER: ❑ M ❑ F
STREET ADDRESS:	EMAIL:		PHONE NO.: ( )
P.O. BOX:	CITY:	STATE:	ZIP CODE:
OCCUPATION:	EMPLOYER:		EMPLOYER PHONE NO.: ( )

CHOSE PRACTICE BECAUSE/REFERRED TO PRACTICE BY (PLEASE CHECK ONE BOX): ❑ DR. ❑ INS. PLAN ❑ HOSPITAL

❑ FAMILY ❑ FRIEND ❑ CLOSE TO HOME/WORK ❑ GOOGLE ❑ OTHER

OTHER FAMILY MEMBERS SEEN HERE:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PERSON RESPONSIBLE FOR BILL:	BIRTH DATE: / /	ADDRESS (IF DIFFERENT):	HOME PHONE NO.: ( )

IS THIS PERSON A PATIENT HERE? ❑ YES ❑ NO

OCCUPATION:	EMPLOYER:	EMPLOYER ADDRESS:	EMPLOYER PHONE NO.: ( )

IS THIS PATIENT COVERED BY INSURANCE? ❑ YES ❑ NO

PLEASE INDICATE PRIMARY INSURANCE ❑ [Insurance]

SUBSCRIBER'S NAME:	SUBSCRIBER'S S.S. NO.:	BIRTH DATE: / /	GROUP NO.:	POLICY NO.:	CO-PAYMENT: $

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

NAME OF SECONDARY INSURANCE (IF APPLICABLE):	SUBSCRIBER'S NAME:	GROUP NO.:	POLICY NO.:

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):	RELATIONSHIP TO PATIENT:	HOME PHONE NO.: ( )	WORK PHONE NO.: ( )

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE DENTIST. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE EMPOWER DENTAL OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

******** PATIENT / GUARDIAN SIGNATURE** **DATE**