# Patient Information Form

Hardy-Webster Dental, PLLC

## Part I: Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ SS# _____

Birth Date: _____ Marital Status: _____ Gender: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Who may we thank for referring you to our office? _____

_____ You have my permission to text me _____ You have my permission to email me

## Patient's or Parent's Employer Information

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

## Emergency Information:

Person to contact in case of emergency? _____ Phone: _____

## Part II: Insurance Information

**Insured Information:**

Name: _____ Relationship to patient: _____

Birth Date: _____ SSI: _____ DL: _____

Employer: _____ Work #: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy ID: _____ Group #: _____ Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Union or Local #: _____

## Assignment and Release

I certify that I, and my dependent(s) have insurance coverage with _____ and assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered.
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.
The above-named dentist may use my health care information and may disclose such information to the abovenamed insurance company and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related service.

_____ Date: _____

Signature of Patient, Parent, Guardian, or Representative