PATIENT INFORMATION **Date** _____

Name _____ __Married __Single __Minor __Male __Female
Last First MI

Social Security # _____

Address _____
Street Apt. # City State Zip

Birthdate ____/____/_____ Telephone _____
Home Cell

*Email _____

Name of Employer _____ Address _____

If full time student, name of school _____ Grade _____

Responsible Party: __ Patient __ Guardian __ Spouse __ Father __ Mother

INSURANCE INFORMATION **I understand Dr. Torie's Dental Shoppe is an out of network provider: _____**
For minors, patient may need to complete both sections for parent information. Initials
Adults, please complete primary insured. (Dual coverage? Also complete secondary insurance)

Primary Insured/If no insurance, complete for responsible party

Last First MI

Street City ST Zip

Birthdate MO/DAY/YEAR Relationship to Patient

Employer Dental Ins. Company

SS# Subscriber # Group #

Phone number of Insurance Company

Secondary Insured

Last First MI

Street City ST Zip

Birthdate MO/DAY/YEAR Relationship to Patient

Employer Dental Ins. Company

SS# Subscriber # Group #

Phone number of Insurance Company

EMERGENCY CONTACT INFORMATION

Name _____

Phone _____

Relationship to Patient _____

How did you hear about Dr. Torie's Dental Shoppe?

_____

AUTHORIZATION

I hereby authorize payment directly to *Dr. Torie's Dental Shoppe* of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize *Dr. Torie's Dental Shoppe* to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical history form are correct to the best of my knowledge. I grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer, including any part necessary to conduct collections. I understand if delinquent in paying invoices I will be subject to interest (1.5% per month, 18% per year), collection costs and attorney fees, venue in Lake County, Indiana. .

X _____ Date _____

State Driver's License # _____