
# gentle dental
ASSOCIATES

**Gentle Hearts, Gentle Hands, Caring for You Like Family**


## Patient Information

Today's Date_____ Patient Name:_____

□ Male □ Female Birthdate:_____ Preferred Phone:_____

Other Phone:_____ E-Mail Address:_____

Address:_____ Apt/Lot:_____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ Phone:_____

Would you like your health information shared with anyone? □ Yes □ No

If yes, please list:_____

## Billing Information

This is the person that is ultimately responsible for billing and payment on the account.

Name:_____ Relation to Patient:_____

Billing Address:_____ Apt/Lot:_____

City:_____ State:_____ Zip:_____

SSN:_____ Phone:_____

Initials: _____ I hereby authorize assignment of my insurance benefits directly to the provider of services.

## Insurance Information

**Primary Insurance:**

Policy Holder's Name:_____ Birthdate:_____

Relation to Patient:_____ Insurance Name:_____

Employer:_____ ID/SSN:_____

**Secondary Insurance:**

Policy Holder's Name:_____ Birthdate:_____

Relation to Patient:_____ Insurance Name:_____

Employer:_____ ID/SSN:_____