Kenneth W. Arnt, D.D.S., LLC

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____ SEX ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

ADDRESS _____
STREET CITY STATE ZIP

PHONES: HOME _____ WORK _____ CELL _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ AGE _____

EMPLOYER OR SCHOOL _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

EMAIL ADDRESS _____ WHOM MAY WE THANK FOR REFERRING YOU? _____

NAMES OF FAMILY MEMBERS TREATED IN OUR OFFICE _____

RESPONSIBLE PARTY INFORMATION (PARENT OR PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT)

IF SAME AS PATIENT ABOVE, CHECK HERE ☐ AND SKIP TO SIGNATURE LINE BELOW

NAME _____ SEX ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

ADDRESS _____
STREET CITY STATE ZIP

PHONES: HOME _____ WORK _____ CELL _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

EMAIL ADDRESS _____

OTHER PARENT OR SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ WORK PHONE _____

CELL PHONE _____ EMAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

NOTE: *ANY BALANCE ON ACCOUNT NOT PAID WITHIN 90 DAYS WILL BE SUBJECT TO INTEREST CHARGES OF 1.5% MONTHLY*

RESPONSIBLE PARTY SIGNATURE:

X _____

INSURANCE INFORMATION

PERSON WHO HOLDS INSURANCE _____ EMPLOYER _____

INSURED'S SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

DO YOU HAVE DUAL COVERAGE? ☐ YES ☐ NO IF YES:

PERSON WHO HOLDS INSURANCE _____ EMPLOYER _____

INSURED'S SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the dentist and, therefore, I am still responsible for all dental fees. I understand that I will be charged for all dental treatment and that any payments received by the Dental Office from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

SIGNATURE OF INSURED X _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

RELATIONSHIP _____ PHONE _____ CELL PHONE _____

ADDRESS _____
STREET CITY STATE ZIP