Thank you for choosing Soukup Dentistry

Patient information

First Name_____Last Name_____

Mailing Address_____

City_____ State_____ Zip_____

Marital Status: M S D W Gender: (Male) (Female) Date of Birth ____/____/_____

School/Employer _____

Social Security Number_____ Cell Phone_____

Work Phone_____ Home Phone _____

E-mail Address_____

Preferred method of contact: (Text) (Email) (Phone Call)

Emergency Contact Name_____Phone Number_____

Relationship to Patient_____Whom May We Thank for Referring You?_____

Dental insurance information

Primary Insurance: _____Subscriber:_____
Insurance is through: (Self) (Spouse) (Mother) (Father) (Guardian)
Employer_____ Subscriber Identification Number_____
Secondary Insurance_____ Subscriber_____
Insurance is through: (Self) (Spouse) (Mother) (Father) (Guardian)
Employer_____ Subscriber Identification Number_____

Parent/Guardian (if a minor) or Spouse information

Parent/Spouse Name _____Date of Birth _____/_____/_____

Address: _____

Social Security Number: _____ Employer_____

AUTHORIZATION AND RELEASE – I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services rendered, and that I am responsible for all copays, deductibles, co-insurance and that I am ultimately responsible for any unpaid balances. I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me, and I consent to receive such calls, text messages, and emails. I further agree that I have read the financial policy, and the notice of privacy practices, and understand that a copy is available to me upon request.

X_____
Signature of Patient / Guarantor