Please print and fill form out with blue or black ink.

PATIENT INFORMATION

NAME ______________________________ AGE _________ SEX __________ MARITAL STATUS ________
SS#__________________________ DOB __________OCCUPATION ____________ PHONE ____________________
STREET ADDRESS___________________________CITY__________________STATE__________ZIP____________
EMPLOYER____EMPLOYER PHONE________________________
EMPLOYER ADDRESS_______________________CITY__________________STATE__________ZIP_____________
ARE YOU A FULL TIME STUDENT___________________IF YES, WHERE___________________________________
PATIENT'S FAMILY PHYSICIAN______________________PATIENT'S GENERAL DENTIST___________________
WHOM MAY WE THANK FOR REFFERING YOU TO OUR OFFICE?______________________________________
DID YOU BRING YOUR REFERRAL SLIP?____________________DID YOU BRING YOUR XRAY?____________
HAVE YOU EVER BEEN A PATIENT IN OUR OFFICE?_________WHICH DOCTOR DID YOU SEE?____________
CONTACT PERSON INCASE OF EMERGENCY?_________________PHONE_____________RELATION_________

PRIMARY RESPONSIBILE PARTY INFORMATION

NAME OF PERSON INSURED___________________________________RELATION TO PATIENT_______________
STREET ADDRESS___________________________CITY__________________STATE__________ZIP____________
DOB_______________________ SS# __________DRIVERS LICENSE# ____________ PHONE _________________
EMPLOYER____EMPLOYER PHONE________________________
EMPLOYER ADDRESS_______________________CITY__________________STATE__________ZIP_____________

PRIMARY INSURANCE COMPANIES (PLEASE PROVIDE US WITH BOTH DENTAL AND MEDICAL INSURANCE)

DENTAL INSURANCE COMPANY_______________________ GROUP#_____________PHONE_________________
BILLING ADDRESS___________________________CITY__________________STATE__________ZIP_____________
MEDICAL INSURANCE COMPANY_______________________ GROUP#_____________PHONE_______________
BILLING ADDRESS___________________________CITY__________________STATE__________ZIP_____________

IF YOU HAVE A SECONDARY AND/OR OTHER INSURANCE COVERAGE, PLEASE FILL OUT INFORMATION ON BACK OF SHEET .

PLEASE READ AND SIGN BELOW (BOTH LINES MUST BE SIGNED)

I HEARBY AUTHORIZE BRIAN D. CUTRIGHT, DDS, INC. TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED.

_____________________________________ _____________________________________
(PATIENT, OR PARENT IF PATIENT IS A MINOR) DATE

I HEREBY AUTHORIZE THE PAYMENT OF BENEFITS MADE DIRECTLY TO BRIAN D. CUTRIGHT, DDS, INC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE AND THAT MY INSURANCE IS BILLED FOR ME AS A COURTESY. ANY COPAYS/DEPOSITS ARE DUE AT THE TIME OF SERVICE.

_____________________________________ _____________________________________
(PERSON RESPONSIBLE FOR ACCOUNT) DATE

Form only needs to be filled out if you have a secondary insurance that needs to be billed.

SECONDARY RESPONSIBLE PARTY INFORMATION

NAME OF PERSON INSURED__________________________________RELATION TO PATIENT______________
STREET ADDRESS__________________________CITY_________________STATE_________ZIP___________
DOB______________________ SS# __________DRIVERS LICENSE# ____________ PHONE ________________
EMPLOYER____EMPLOYER PHONE________________________
EMPLOYER ADDRESS______________________CITY_________________STATE_________ZIP_____________

SECONDARY INSURANCE COMPANIES (PLEASE PROVIDE US WITH BOTH DENTAL AND MEDICAL INSURANCE)

DENTAL INSURANCE COMPANY______________________ GROUP#_____________PHONE________________
BILLING ADDRESS_________________________CITY_________________STATE_________ZIP_____________
MEDICAL INSURANCE COMPANY______________________ GROUP#_____________PHONE______________
BILLING ADDRESS_________________________CITY_________________STATE_________ZIP_____________

OTHER RESPONSIBLE PARTY INFORMATION (IF THERE IS A THIRD RESPONSIBLE PARTY)

NAME OF PERSON INSURED__________________________________RELATION TO PATIENT______________
STREET ADDRESS__________________________CITY_________________STATE_________ZIP___________
DOB______________________ SS# __________DRIVERS LICENSE# ____________ PHONE ________________
EMPLOYER____EMPLOYER PHONE________________________
EMPLOYER ADDRESS______________________CITY_________________STATE_________ZIP_____________

OTHER INSURANCE COMPANIES (PLEASE PROVIDE US WITH BOTH DENTAL AND MEDICAL INSURANCE)

DENTAL INSURANCE COMPANY______________________ GROUP#_____________PHONE________________
BILLING ADDRESS_________________________CITY_________________STATE_________ZIP_____________
MEDICAL INSURANCE COMPANY______________________ GROUP#_____________PHONE______________
BILLING ADDRESS_________________________CITY_________________STATE_________ZIP_____________