Kari Mann DENTAL STUDIO

Welcome to our office. We are committed to providing you with exceptional state of the art dentistry, based on your individual needs and always meeting a standard of care which ensures excellence.

Patient name: _____ **Date of Birth**: _____ **Sex:** _____ **Age**:_____

Driver's License: ____Please Show ID_____ **Social Security Number**: _____ (*necessary for billing purposes)*

Home/Mailing address: _____ **City:** _____ **State**: ____ **Zip**: _____

Home phone: _____ **Cell**:_____ **Email**: _____

Circle Your Preferred Method of Contact for Appointment Reminders: Text Email Home Phone Message Cell Phone Message

Your Occupation: _____ **Whom may we thank for referring you?** _____

Emergency Contact: _____ **Relationship to Patient**: _____ **Phone #**: _____

Name of your previous dentist: _____ **Date of last visit to dentist**: _____

Primary Insurance – Required to Bill Insurance	**Secondary Insurance – Required to Bill Insurance**
Subscribers Name	Subscribers Name
____/____/____ Date of Birth ____ SSN (If different from above)	____/____/____ Date of Birth ____ SSN (If different from above)
Subscribers Relationship to Patient	Subscribers Relationship to Patient
Employer ____ Work Phone #	Employer ____ Work Phone #
Name of Insurance Company	Name of Insurance Company
Group # ____ ID # -Required to bill insurance	Group # ____ ID # -Required to bill insurance

We understand insurance guidelines can be hard to understand and overwhelming at times. Your insurance is a contract between you and your insurance company. We will do our best to assist you in processing your insurance claims. However, your insurance company makes final determination once treatment is completed and the claim is submitted. You are ultimately responsible for the full amount of services rendered.

Signature:_____ Date: _____

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