Wilson & Wilson Dentistry
LET OUR FAMILY TAKE CARE OF YOURS

PERSONAL INFORMATION

Patient's Name _____
First Name M Last Name Preferred Name

Mailing Address _____ Birth Date _____

City, State _____ Zip _____ SSN _____

Email Address _____ Gender ☐Male ☐Female

Home Phone _____ Marital Status ☐Single ☐ Married ☐ Other

Mobile Phone _____

Work Phone _____ Employer _____

We offer an electronic messaging reminder service, may we contact you via:
☐ Text Message ☐Email ☐Both ☐Neither [Preferences can be changed at any time]
How did you hear about our office? ☐Personal Reference ☐Drive-by ☐Phonebook
☐ Internet search ☐Facebook ☐Google ☐Google Ad ☐Yelp ☐Health Grades ☐Other: _____

If someone referred you, whom may we thank? _____

In case of emergency, please contact: _____ Phone _____

RESPONSIBLE PARTY INFORMATION (if not self)

Name _____
First Name M Last Name Relationship to Patient

Mailing Address _____

City, State _____ Zip _____ Birth Date _____

Email Address _____ SSN _____

Home Phone _____ Gender ☐Male ☐Female

Work Phone _____ Marital Status ☐Single ☐ Married ☐ Other

Mobile Phone

INSURANCE & EMPLOYER INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Subscriber Contact Number _____

Subscriber Birth Date _____

Subscriber ID or SSN _____

Group Number _____

Dental Insurance Carrier _____

Subscriber Employer

SECONDARY INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Subscriber Contact Number _____

Subscriber Birth Date _____

Subscriber ID or SSN _____

Group Number _____

Dental Insurance Carrier _____

Subscriber Employer

AUTHORIZATIONS

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Wilson & Wilson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature Date

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be _____.

_____
Signature Date