



Garret Family Dental Care
 15009 West Bell Road, Suite 175
 Surprise, Arizona 85374-3213
 Phone 623.476.8100
 Fax 623.792.5311
 garrettdental@gmail.com

PATIENT INFORMATION UPDATE

PATIENT OR RESPONSIBLE PARTY, COMPLETE THE FOLLOWING.

NAME _____ TODAY'S DATE _____
First Last

STATUS Married Single Partnered Minor (Under 18 yrs) Other _____

E-MAIL _____

STREET _____

CITY _____ STATE _____ ZIP _____

EMPLOYER/SCHOOL OF PATIENT _____

SPOUSE'S NAME _____ BIRTH DATE _____

LIST ALL DEPENDENTS WITH YOUR FAMILY THAT ARE ALSO PATIENTS WITH US.

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTHDATE _____
First Last

NAME _____ BIRTH DATE _____
First Last

PHONE NUMBERS

LIST ONLY THE PHONE NUMBERS THAT YOU WISH US TO CONTACT YOU ON.

PHONE _____ Ext _____ Mobile Home Work Other

PHONE _____ Ext _____ Mobile Home Work Other

PHONE _____ Ext _____ Mobile Home Work Other

EMERGENCY CONTACT

THE FOLLOWING WILL BE CONTACTED (SPECIFY INDIVIDUAL NOT LIVING WITH YOU).

NAME _____ RELATIONSHIP _____

PHONE _____ Ext _____ Mobile Home Work Other





Garret Family Dental Care
 15009 West Bell Road, Suite 175
 Surprise, Arizona 85374-3213
 Phone 623.476.8100
 Fax 623.792.5311
 garrettdental@gmail.com

PATIENT INFORMATION UPDATE

DENTAL INSURANCE

PRIMARY

INSURANCE CO _____ PHONE _____

GROUP # _____ GROUP NAME _____

SUBSCRIBER (POLICY HOLDER) _____

MEMBER ID (MIGHT BE SS #) _____ BIRTH DATE _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER Self Spouse Child Other _____

Is the patient covered by additional insurance? No Yes (If yes, complete next section)

SECONDARY

INSURANCE CO _____ PHONE _____

GROUP # _____ GROUP NAME _____

SUBSCRIBER (POLICY HOLDER) _____

MEMBER ID (MIGHT BE SS #) _____ BIRTH DATE _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER Self Spouse Child Other _____

NO INSURANCE

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company(ies). I assign directly to Garrett Family Dental Care 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 authorize the use of my signature on all insurance submissions.

Dr. Garrett may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining the insurance benefits or the benefits payable for related services. This consent will remain in effect until your relationship with the above named Insurance Company(ies) ends.

X

 Signature of Patient or Responsible Party Date

 Print name of Patient or Responsible Party Relationship to Patient

DISCOUNT PLAN

- Aetna Dental Access
- American Dental Plan
- American Health Benefits
- AmeriPlan

- Appleton
- Careington POS/500 Series
- Cigna PNA/AHC
- DDS – Schedule D

- Fourstar
- HealthPlus
- Savon
- Smile Bright

- UniCare 100/200
- UnitedHealth Allies Plan
- OTHER** _____

MEMBER ID # _____ EXPIRATION DATE _____

X

 Signature of Patient or Responsible Party Date

