BELL FAMILY DENTISTRY

3607 E. Bell Rd. Suite 5, Phoenix, AZ 85032 • www.SmilesOnBell.com • 602-296-4664

New Patient Information

Patient Information

Patient Name _____

Social Security # _____

Address _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

☐ Male ☐ Female Date of Birth _____

Employer/School _____

May we contact you by email or text message?

☐ Appointment Confirmation

☐ Billing Questions

Email Address _____

How did you hear about Bell Family Dentistry?

☐ Personal Referral _____

☐ Mailing ☐ Phone Book _____

☐ Newspaper Ad ☐ Building sign ☐ Insurance Company

☐ Website ☐ Other _____

Primary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID # _____

Address (if different from patient) _____

_____

Subscriber's Employer _____

Insurance Company _____

Group # _____

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

Secondary Dental Insurance

Subscriber Name _____

Relationship to Patient _____

Date of Birth _____ SS/ID# _____

Address (if different from patient) _____

_____

Subscriber's Employer _____

Insurance Company _____

Group # _____

Assignment and Release

If you have dental insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage with _____ and assign directly to
Name of Insurance Company

Bell Family Dentistry and its associates 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.

Bell Family Dentistry and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

_____
Signature of patient or personal representative

_____
Print name of patient or personal representative

_____ _____
Date Relationship to patient

Contact Information

Phone: Home _____ Cellular _____ Work _____

May we call your work to reach you? ☐ Yes ☐ No E-mail _____

EMERGENCY CONTACT INFORMATION

Name _____ Home Phone _____ Cellular _____