DR. MATTHEW **RYAN**

PATIENT INFORMATION

Welcome! Please tell us who recommended our practice to you. We'd like to thank them. _____

_____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ ST:_____ Zip: _____

Mobile Phone: _____ Work Phone:_____

Home Phone: _____ E-Mail: _____

Name of Parent or Guardian (if applicable): _____

Mobile Phone: _____ Work Phone:_____

Home Phone: _____ E-Mail: _____

Address: _____ City: _____ ST:_____ Zip: _____

If the patient is a minor, will someone other than a legal guardian accompany the patient to appointments at our practice?
☐ Yes ☐ No If yes, please request and complete the AUTHORIZATION FOR A CARETAKER TO ACCOMPANY A MINOR PATIENT form.

Whom shall we notify in case of emergency?

Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Employer: _____

Employee Name:_____

Insurance Company Name: _____

Address: _____

City:_____ST:_____ Zip:_____

Insurance Phone: _____

Group / Policy #: _____

Social Security #: _____
(Required by your dental benefits provider)

Subscriber I.D. #:_____

Date of Birth: _____

Employer: _____

Employee Name:_____

Insurance Company Name: _____

Address: _____

City:_____ST:_____ Zip:_____

Insurance Phone: _____

Group / Policy #: _____

Social Security #: _____
(Required by your dental benefits provider)

Subscriber I.D. #:_____

Date of Birth: _____

IF YOU ARE COVERED BY MORE THAN ONE INSURER OR DENTAL PLAN

Every dental insurance company or dental benefits plan has a policy to coordinate the payment of dental care when a patient has coverage with more than one insurance carrier. The following questions will help your dentist to determine your primary insurer.

- Which coverage is primary (i.e., the plan that covers you other than as a dependent)?

_____

- If you have two dental benefits plans that are primary (i.e., they both cover you as the primary policyholder), which plan has covered you the longest?

_____

If the patient is a dependent child covered by the insurance plans of both parents, list the date of birth of each parent.

Insured Name: _____ Date of Birth:_____

Insured Name: _____ Date of Birth:_____

Note: Dental insurers consider the benefits plan of the parent with the earlier birth date in the calendar year to be the primary insurer of children who are covered by the benefits plans of both parents.

- If the patient is a dependent child of parents who are separated or divorced, which parent, if either, has custody of the child?

  ☐ Mother ☐ Father ☐ Other: _____

- Has the parent with custody remarried? ☐ Yes ☐ No

- If the parents of the minor child are divorced, is there a court order that directs which parent has financial responsibility for the child, regardless of who has custody? ☐ Yes ☐ No

  If yes, which parent? _____

- Does the patient have coverage under his or her current employment and through a former employer (e.g., as a laid-off employee or a retired employee)? ☐ Yes ☐ No

- Does the patient have coverage under a right of continuation under a former plan? ☐ Yes ☐ No

PATIENT ACKNOWLEDGMENT:

I certify that I have read (or had read to me), understand, and agree to the contents of this form.

Signature: _____ Date: _____

(Parent or Guardian if a minor)