Grace Family Dentistry

143 Airport Road, Concord, New Hampshire 03301
Tel: 603-225-6650 Toll Free: 800-407-8478
Fax: 603-225-9495

About You

Today's Date:____/____/____ Birth Date: ____/____/____

Patient Name: ________________ ☐M ☐_F__

Street Address: ________________

City: __________ State: ______ Zip: ______

Mailing Address: ________________

City: __________ State: ______ Zip: ______

Home #: __________ Cell #: __________

Email Address: ________________

Occupation: __________ Work #: __________

Employer: ________________

Status: ☐ minor ☐ single ☐ married ☐ divorced

Spouse's Name: ________________

Referred here by: ________________

Insurance

Primary Dental Insurance

Insured's Name: ________________

Relation to Patient: ________________

Insured's Employer: ________________

Insured's ID #: ________________

Group #: ________________

Ins Co. Name: ________________

Phone#: ________________

Secondary Dental Insurance

Insured's Name: ________________

Relation to Patient: ________________

Insured's Employer: ________________

Insured's ID #: ________________

Group #: ________________

Ins Co. Name: ________________

Phone#: ________________

Account Information

Person Responsible for Account

Name: ________________

Relation: ________________

Billing Address: ________________

City: __________ State: ______ Zip:______

Phone# ________________

SS Number: ________________

Payment is due at the time services are rendered

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely ________ responsible for any balance not paid by my insurance carrier.

Initials

Emergency Info

Contact Person: ________________

Relation: ________________

Home # ________________

Cell # ________________

Work # ________________

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OTHER SIDE →