GLEN BURNIE FAMILY DENTAL

Patient Information

Name _____ SS# _____
LAST FIRST MIDDLE

Date of Birth _____ Preferred Pronoun_____ Marital Status_____

Address _____ City_____ State _____ Zip_____

Home Phone # _____ Cell Phone # _____ Work/Other Phone #

Employer _____ Occupation _____

Responsible Party Name_____ Phone Number _____

Dental Insurance Information

Policy Holder's Name_____ Date of Birth

SS# _____ Name of Employer

Primary Insurance Company_____ ID # _____

Secondary Insurance Company _____ ID# _____

*** Please be prepared to provide your insurance cards and ID**

Previous Dentist/ Emergency Contact

Previous Dentist Name_____ Phone Number _____

Date of Last Exam _____ Date of last X Ray _____

Reason for Today's Appointment _____

Any Major Dental Procedures _____

Emergency Contact Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Employer _____

Final Notes

A minimum charge will be made for failed or canceled appointments without prior notification of at least 24 hours.

I hereby authorize the office of Glen Burnie Family Dental, to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to GBFD from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co payment, deductible and non-covered services.
I agree to pay my bill in full for services rendered by Glen Burnie Family Dental.

Patient's Signature _____ Date _____