EMMANUEL
Dental & Fastbraces

445 Walnut Street, Suite 133
Richardson, TX 75040
Phone: 972-238-7233
Fax: 972-238-8993
Email: smile@drpramod.com

Today's Date:_____ Email Address: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

GETTING TO KNOW YOU

NAME:_____
LAST FIRST MIDDLE

Maritial Status: ☐ Married ☐ Widowed ☐Single ☐Minor ☐ Separated ☐Divorced ☐Partnered for _____ years

Birthdate: ____/____/_____ Age:_____ SSN:_____

Home Address:_____

City:_____State:_____Zip:_____

Home Phone:(___)_____ Business Phone: (___)_____

Cell Phone:(___)_____

I perfer to be contacted by: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

EMPLOYER:_____

Work Address:_____Occupation:_____

★Please tell us how you heard about our office: □ Internet □ Flyers
□ Mailer □ Other: _____
□ Patient /Friends/Family(Whom may we thank): _____

Spouse Information: Name:_____ DOB: _____

Employer: _____ Position:_____

Work Phone: _____ SSN: _____

Emergency Contact Name : _____Relationship:_____

Home Phone: _____ Work/Cell Phone: _____

Person Responsible for Account (if other than yourself)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Employer: _____ SSN:_____

INSURANCE INFORMATION

Primary Dental Insurance: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address:_____

_____

Insurance Co. Phone: _____

Group #: _____ Member #: _____

Insured's Name: _____

Relation to the insured: _____

Insured's Birthdate: _____/_____/_____

Insured's SSN: _____

Insured's Employer:_____

Secondary Dental Insurance: ☐ Yes ☐ No

ACKNOWLEDGEMENT

I certify that I (or my dependent) have insurance coverage with the above named insurance company (companies) and assign directly to Emmanuel Dental all insurance benefits. I understand that I am financially responsible for all charges: any deductible amount, Co-insurance, or any balance not paid for by my insurance company (if I may have one). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party
Signature: _____