



DEEANN BENNETT DDS, PA
cosmetic and family dentistry

Patient Information

Patient Name: _____
Last First Middle Preferred Name

Birthdate _____ Male/Female Marital Status: **S M D W Child**

Social Security # _____ Full-Time College Student Y/N If so, where? _____

Address _____
Street Apt # City State Zip Code

Please Provide all telephone numbers (circle preferred number)

Home _____ Work _____ ext _____ Cell _____

Email Address _____ Employer _____

Other Family Members in this Practice _____

Spouse's Name _____ Birthdate _____ SS# _____

Spouse's Employer _____ Spouse Work Phone _____

Whom may we thank for referring you? _____

Responsible Party Information

Self _____ Other _____
Last First Middle

Please complete for "other"

Birthdate _____ Social Security # _____

Address _____
Street Apt # City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Insurance Carrier _____ Name of Insured _____ Insured's DOB _____

Relationship to Patient _____ Insured's SS # _____

ID# _____ Employer _____ Employer Address _____

Insurance Address _____ Insurance Phone _____

I authorize and request my insurance company to pay insurance benefits to directly pay Deeann Bennett, D.D.S., P.A. New patients with insurance agree to pay initial fees at time of service. I understand that my dental insurance carrier may pay less than the actual estimate. I agree to be responsible for payment of all services rendered on behalf of myself and my dependents. I agree to pay account balances over 90 days in full.

Patient, Parent or Guardian Signature

Date