GRANDVIEW DENTAL
ADAM MCLACHLAN DDS

Patient Intake From

Patient Information

Name: _____ Birthdate: _____

Preferred Name: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip:_____

Cell Phone: _____ Other Number: _____ Email: _____

SSN: ____-____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnership ☐ Widowed

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Referral

How did you learn about our office or whom may we thanks for referring you? _____

Responsible Party

Who is responsible for your account and payment? (If someone other than yourself) _____

Relationship: _____ Phone Number: _____

Dental Insurance

Primary Insurance	Secondary Insurance
Subscriber Name	Subscriber Name
Subscriber ID	Subscriber ID
Date of Birth	Date of Birth
Relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name	Employer Name
Insurance Company	Insurance Company
Insurance Group Number	Insurance Group Number
Insurance Phone Number	Insurance Phone Number

Authorization

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may be less than the actual bill for service and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

ELECTRONIC COMMUNICATIONS. I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt out of receiving electronic communications at any time by letting the office know.

Signature _____ Date _____

(Responsible party if under 18 years old)