Indy Dental Group®
Comprehensive, Cosmetic & Family Dentistry

www.indydentalgroup.com

Patient Name____
First (Legal) Last Middle Initial (Preferred First Name)

Birth Date______________________ Age________ Sex ☐ M ☐ F Social Security ____________________________________

Address____ City________________ State___________ Zip Code_______________

CELL Phone_______________________HOME Phone__________________WORK Phone________________________

Email Address____

I would like to receive confirmation messages by: TEXT ☐ YES ☐ NO EMAIL ☐ YES ☐ NO

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered ☐ Minor ☐ Full Time College Student

Patient Employer or School ____ Patient Occupation_____________________________

Emergency Contact: ____Relationship________________Phone____________________________

I found Indy Dental Group through:

☐ *Insurance* ☐ *Friend* ☐ *Family* ☐ *Web Site / Internet* ☐ *Other* *Whom should we thank for referring you?* ________________________

DENTAL - Primary Insurance: ☐ YES ☐ NO		DENTAL - Secondary Insurance: ☐ YES ☐ NO	
Subscriber Name:	Relationship to Patient:	Subscriber Name:	Relationship to Patient:
Subscriber ID/ Social Security #:	Date of Birth:	Subscriber ID/ Social Security #:	Date of Birth:
Insurance Company:	Employer:	Insurance Company:	Employer:

Authorization and Documentation Review

By signing below, I am confirming all of the above information is correct. I certify that I, and/or my dependents, have the above insurance and agree to assign all insurance payments / benefits paid directly to Indy Dental Group for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. Indy Dental Group may use my health care information and may disclose such information to my Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize dental treatment for myself and /or my family member.

____________________________Date__________ Signature of Patient, Parent, or Legal Guardian	____________________________Date__________ Signature of Patient, Parent, or Legal Guardian
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