Barnstable Dental Associates

15 Cedar St. Hyannis, MA 20601

Personal & Billing Information

(Please Print & Complete All Information)

Patient Information

Patient's Last Name:	First:	Middle Init:	☐ **Ms.** ☐ **Mr.** ☐ **Mrs.** ☐ **Miss**	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐
DOB:	SS#	I preferred to be called by the name:		
Street Address:		P.O. Box:		
City:	State:	Zip Code:		
Home Phone #:	Work #	Cell #:		
Preferred Phone # for contact (please circle all that apply): Home Cell Work	E-Mail			

If Minor-Name of Parent/ Guardian	Relationship to Patient:

Employer:	Occupation:
Employer's Address:	Town:

Dental Insurance Information

(Please give your insurance card to the receptionist)

Dental Ins. Co. :	Subscriber's Name:
Subscriber's ID:	Subscriber's DOB:
GR#/ Policy #:	Subscriber's Employer:

Secondary Dental Insurance

Dental Ins. Co.:	Subscriber's Name:
Subscriber's ID:	Subscriber's DOB:
Gr#/ Policy#	Subscriber's Employer:

How did you hear about us?	**Whom may we thank for referring you?**

In Case of Emergency

Name of local friend or relative:	Relationship to patient:	Home or Cell phone #:	Work Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Barnstable Dental Associates. I understand that I am financially responsible for any balance. I authorize Barnstable Dental Associates or insurance company to release any information required to process my claims. I understand it is my responsibility to inform Barnstable Dental Associates of any changes to the above information.

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Patient/ Parent/ Guardian Signature ***Date***