Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

Confidential Patient Information

Date:_____

Please print clearly.

I. Patient Information

Name:_____ **Birthdate**:_____ **Gender**:_____
Address:_____ **City & State**:_____ **Zip:**_____
Home Phone: (_____)_____ **Cell Phone**: (_____)_____ **Email**:_____
Social Security #:_____ **Driver's License #**:_____
Employer's Name:_____ **Phone #**: (_____)_____**Marital status**:_____

II. Responsible Party (Primary Insurance Information)

Name:_____ **Relationship to Patient**:_____
Social Security #:_____ **DL#**:_____ **Birthdate:**_____
Name of Employer:_____ **Phone Number**:_____
Address:_____ **City:**_____ **Zip**:_____
Name of insurance:_____ **Phone #**:_____
Union/Local:_____ **Group number**:_____ **Occupation:**_____
Date of Hire:_____

III. Second Insurance information (Only complete if patient has other coverage)

Name:_____ **Relationship to Patient**:_____
Social Security #:_____ **DL#**:_____ **Birthdate**:_____
Name of Employer:_____ **Phone Number**:_____
Address:_____ **City:**_____ **Zip**:_____
Name of insurance:_____ **Phone #**:_____
Union/Local:_____ **Group number**:_____ **Occupation**:_____
Date of Hire:_____

IV. Getting to know you and your family

How did you hear about Infinity Dental?:_____ **Last dental x-rays taken**?_____
When was your last dental visit?:_____ **What treatment was performed**?:_____

Please list all immediate family members:

Name: **Relationship:** **Birthdate:** **Date of last dental visit**:

_____
_____
_____
_____

V. Emergency Contact (Friend or relative not living with you)

Name:_____ **Phone:** (_____)_____

SO WE MAY BILL YOUR INSURANCE DIRECTLY, PLEASE SIGN

I hearby authorize payment directly to Infinity Dental of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges.

_____ **Date:**_____

Signature of Patient/Guardian