

**Patient Information**

Name:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Birth date:	Soc. Sec. #:
Address:	City/State: ZIP:
Home Phone#:	Cell Phone #:
Employer:	Work Phone #
Email Address:	
Whom May We Thank For Referring You?	

**Person Responsible For Account (if different from patient)**

Name:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Birth date:	Soc. Sec. #:
Address:	
Home Phone#:	Cell Phone #:
Relationship to patient:	

**Dental Insurance Information**

**Primary**

Ins. Co:	Employer:
Subscriber ID#:	Group #:
Policy Holder:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Birth date:	Soc Sec #:

**Secondary**

Ins. Co:	Employer:
Subscriber ID#:	Group #:
Policy Holder:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Birth date:	Soc Sec #:

**Assignment & Release**

I agree to assign directly to West Somerville Dental Associates all insurance benefits, if any, payable to me for service rendered. I understand that I am financially responsible for all charges not covered by my insurance carrier.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date