Dupont Dental Office

3932 Dutchmans Lane
Louisville, KY 40207
502-895-0797

Patient Name: _____ ☐ Male ☐ Female
Preferred Name: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Address: _____ City _____ State _____
ZIP_____
SSN: _____ DOB: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Who may we thank for referring you to our office?
_____

Dental Insurance – Primary
Subscriber Name: _____ Relationship to Patient: _____
Subscriber DOB: _____ Subscriber SSN/ID: _____
Subscriber Employer: _____
Insurance Company Name:
_____
Insurance Company Address:
_____
Insurance Company Phone: _____ Group Number: _____

Dental Insurance – Secondary
Subscriber Name: _____ Relationship to Patient: _____
Subscriber DOB: _____ Subscriber SSN/ID: _____
Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address:
_____
Insurance Company Phone: _____ Group Number: _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dupont Dental Offices all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____