



15946 Redmond Way Suite 106 • Redmond, WA 90852 • 425-898-2168

### Patient's Information

Today's Date: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Preferred Pronoun:  He  She  They

Date of Birth: \_\_\_\_\_  male  female

Home Address: \_\_\_\_\_

\_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Cellphone #: \_\_\_\_\_ Home #: \_\_\_\_\_

Work #: \_\_\_\_\_

Email: \_\_\_\_\_

Which is the best way to reach you?

Cellphone  Home Phone  Work Phone  Email

### How did you hear about us?

Google  Bing  YELP  Insurance Search

Other: \_\_\_\_\_

What Keywords did you use to find us?

(e.g. Redmond Dentist, emergency dentist, etc)

\_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

### Insurance Information

Name of Policy Holder: \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

\_\_\_\_\_

### Secondary Insurance Information

Name of Policy Holder: \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Policy Holder Phone #: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

\_\_\_\_\_

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to Redmond Way Dentistry for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_