James M. Cooper D.D.S.

Adult Patient Information

Date_____

Patient Name_____ Preferred Name_____

Date of Birth_____ Social Security #_____

Single_____ Married_____ Divorced_____ Widowed_____ Sex Male Female

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Other_____ Email_____

May We Text You **YES** **NO** May We Email You **YES** **NO** May We Leave A Message **YES** **NO**

Spouse's Name_____

Emergency Contact _____ Phone_____

Who May We Thank for Referring You_____

Are You Covered By Any Dental Insurance **YES** **NO** If Yes, What Insurance:_____

Subscriber:_____ ID#: _____

Date of Birth:_____ Insurance Phone # :_____

Person Financially Responsible_____ Relationship_____

Address _____ Phone_____

AUTHORIZATION/SIGNATURE ON FILE

I hereby authorize treatment and authorize the provider to release medical information necessary to submit claims to my insurance company, to provide necessary information to the insurers and appeal claims on behalf of myself. I understand and agree that a copy of this authorization and/or assignment of benefit, when signed by me, or an authorized representative, may be sent to my insurance company. I understand that I am financially responsible for all charges not covered by insurance. I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature Date