Virginia H. Ellis, DDS
Dental Corp.
Family and Cosmetic Dentistry

Patient Information

Circle One: Dr/Mr/Mrs/Ms/Miss I prefer to be called:_____

First:_____ Middle:_____ Last:_____

Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Please contact me via: **Text Cell Email Home Phone**

Patient Social Security Number:_____ Date of Birth:_____ Sex: **M F**

Emergency Contact/Relationship:_____ Phone:_____

How did you hear about us?

□Website □Newsletter in Mail □Facebook □Saw our Office/Sign □Search Engine (Google, Yelp)

□Friend/Relative: □Other:

Insurance Information:

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	□Self □Spouse □Child □Other	Relationship to Subscriber	□Self □Spouse □Child □Other
Employer Name		Employer Name	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
PLEASE PRESENT YOUR INSURANCE CARD TO OUR OFFICE MANAGER TO BE PHOTOCOPIED			

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Virginia H. Ellis to act as my agent in helping me obtain payment from my insurance companies. I authorize payment to Virginia H. Ellis, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers and email addresses for the purpose of treatment, insurance, or payment.

Patient/Guardian Signature:_____ Date:_____

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