



**Patient Information**

First Name \* 
 Last Name \* 
 Middle Initial 
 Title

Preferred Name 
 Date of Birth \* 
 Gender \*  Male  Female
 Social Security Number

Address \* 
 City \* 
 State \* 
 Zip Code \*

Home Phone 
 Cell Phone 
 Work Phone 
 Email

Employer 
 Occupation 
 Marital Status \*  Single  Married  Divorced  Widowed   
 Seperated  Domestic Partner

Do you prefer to be contacted for appointment confirmation via e-mail or phone? \*   
 Email  Phone

How did you hear about our office?

**Responsible Party Information**

First Name 
 Last Name 
 Relationship to Patient 
 Date of Birth

SSN/ID 
 Phone Number 
 Employer

Spouse Name 
 Spouse's SSN/ID 
 Spouse's Employer 
 Spouse's Date of Birth

**Insurance**

Subscriber First Name 
 Subscriber Last Name 
 Relationship to Patient 
 Date of Birth

mm/dd/yyyy

Subscriber SSN/ID

\_\_\_\_-\_\_\_\_-\_\_\_\_

Subscriber Employer

\_\_\_\_\_

Insurance Company

\_\_\_\_\_

Insurance Phone Number

(\_\_\_\_) \_\_\_\_-\_\_\_\_

Group Number

\_\_\_\_\_

Insurance Company Address

\_\_\_\_\_

City

\_\_\_\_\_

State

Pleas... ▼

Zip Code

\_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pham Dentistry all medical and/or dental insurance benefits, or third party payer, 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 also acknowledge that any account that goes beyond 60 days past due will be transferred to Transworld Systems Inc. for accounts receivable assistance. Should this be necessary, a service fee/rebilling fee will be added to my account of at least \$25. Interest may be applicable. 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 \*

[Signature area]

Today's Date

05/18/2026

Relationship

\_\_\_\_\_