Welcome to Star Dentistry

Great Smile, Good Life

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you

Patient Information									
Last Name									
First Name									
Date of Birth				Phone Number					
Gender		M		F		Married		Yes		No	
Address									
City				State					
Zip Code			Alternate Phone Number						
Email									
Employer/School									
Employer/School Phone									
Employer/School Address									
City			State			Zip Code			
Spouse or Parent's Name									
Employer									
Work Phone									
Who may we thank for referring you?									
Emergency Contact			Phone			Relationship			

Responsible Party									
Name of Person responsible for this Account									
Relationship to Patient									
Address									
Phone			Driver's License						
Date of Birth			Bank						
Employer									
Work Phone									
Current Patient?		Yes		No					
Email									

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Primary Insurance Information		Secondary Insurance Information
Name of Insured		
Relation to Patient		
Date of Birth		
Social Security #		
Employer		
Date Employed		
Work Phone		
Employer Address		
City		
State		
Zip Code		
Insurance Company		
Phone Number		
Member ID		
Group Name		
Group ID		
Deductible Amount		
Deductible Used YTD		
Max Annual Benefit		

Authorization & Release

To the best of my knowledge, the above information is complete and correct.
I certify that I, and/or my dependent(s), have insurance coverage with :
_____ and assign directly to Dr. Botchway-Manu 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

(signature) _____ Date: _____

Name: _____ Relationship to Patient: _____