Date_____

Name_____Birthdate_____

Physical Address (911 address)_____

City_____State_____ZIP_____**Home** Phone_____

Billing Address_____

City_____State_____ZIP_____**Cell** Phone_____

Employer_____ Occupation_____

Business Address_____

City_____State_____ZIP_____**Business** Phone_____

Social Security Number_____ Email Address:_____

Emergency Contact: Name _____Phone_____

Address _____

Referred By_____ Dentist_____

Individual Responsible for payment if other than the patient_____

Primary Dental Insurance_____ Phone_____

Subscriber's Name_____Employer_____

SS#_____Group #_____ Subscriber's Birth date_____

Secondary Dental Insurance_____Phone_____

Subscriber's Name_____Employer_____

SS#_____Group #_____ Subscriber's Birthdate_____

The office of Daniel R. Kelly, D.M.D., and Ellen Ramos Kelly, D.M.D., P.L.C. comply with HIPPA regulations. I have had an opportunity to review a copy of the Notice of Privacy Practices. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I authorize release of any information relating to this claim. I certify that I am the patient or duly authorized to furnish the information requested. I understand that even though I have some insurance coverage, I am responsible for payment of services.

_____ _____

{Printed Name} {Signature}