Colorado Premier Dental, PLLC

Complete Family, Cosmetic
& Oral Rehabilitative Dentistry

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT INFORMATION (CONFIDENTIAL)

Name:___________________________________ Birthdate:________________

Soc. Sec. #___________________

Home phone________________________Cell phone________________________

Address________________________________City_______________Zip_______

Check one:____Minor____Single____Married____Divorced____Widow

Name of Employer____

Address____

City__________________________Zip__________Phone___________________

Referred by_________________________________

INSURANCE INFORMATION:

Name of insured_______________________Relationship to patient_________________

Insured Soc. Sec. #____________________Birthdate______________________

Name of Insurance company____

Address____

Group #______________Policy/ID #____________Phone #_________________

Additional Insurance Information_____________________________________

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Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. All the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Colorado Premier Dental PLLC/ Dr. Brian J. Polidori DDS to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to Colorado Premier Dental PLLC/ Dr. Brian J. Polidori DDS or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services based off what my insurance plan covers. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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Signature of patient (or guardian of minor) Date

Please turn over to complete past medical history