

Infinity Dental  
8940 W. Tropicana Ave  
Las Vegas, NV. 89147  
702-248-4448

## Confidential Patient Information

Date: \_\_\_\_\_

Please print clearly.

### I. Patient Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Marital status: \_\_\_\_\_

### II. Responsible Party (Primary Insurance Information)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Union/Local: \_\_\_\_\_ Group number: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Hire: \_\_\_\_\_

### III. Second Insurance information (Only complete if patient has other coverage)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Union/Local: \_\_\_\_\_ Group number: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Hire: \_\_\_\_\_

### IV. Getting to know you and your family

How did you hear about Infinity Dental?: \_\_\_\_\_ Last dental x-rays taken? \_\_\_\_\_  
When was your last dental visit?: \_\_\_\_\_ What treatment was performed?: \_\_\_\_\_

### Please list all immediate family members:

Name:	Relationship:	Birthdate:	Date of last dental visit:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### V. Emergency Contact (Friend or relative not living with you)

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### SO WE MAY BILL YOUR INSURANCE DIRECTLY, PLEASE SIGN

I hereby authorize payment directly to Infinity Dental of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. I authorize dental care and the release of any information necessary to bill my insurance carrier. In the event of default, I understand that I will be charged and I agree to pay all reasonable collection charges.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient/Guardian