



1307 South Gold Street • Centralia, WA 98531
 (360) 736-1114
 www.centraliadentist.com

PERSONAL INFORMATION

Patient's Name _____
 First Name _____ M _____ Last Name _____ Preferred Name _____

Mailing Address _____

City, State _____ Zip _____ Birth Date _____

Email Address _____ SSN _____

Home Phone _____ Gender Male Female

Work Phone _____ Marital Status Single Married Other

Mobile Phone _____

We offer an electronic messaging reminder service, may we contact you via:

Text Message Email Both Neither [Preferences can be changed at any time]

How did you hear about our office?

Personal Reference Internet search Facebook Phonebook Drive-by Billboard Other: _____

If someone referred you, whom may we thank? _____

RESPONSIBLE PARTY INFORMATION (if not self)

Name _____
 First Name _____ M _____ Last Name _____ Relationship to Patient _____

Mailing Address _____

City, State _____ Zip _____ Birth Date _____

Email Address _____ SSN _____

Home Phone _____ Gender Male Female

Work Phone _____ Marital Status Single Married Other

Mobile Phone _____

INSURANCE & EMPLOYER INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Subscriber Birth Date _____

Subscriber ID or SSN _____

Group Number _____

Dental Insurance Carrier _____

Subscriber Employer _____

Subscriber Occupation _____

SECONDARY INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Subscriber Birth Date _____

Subscriber ID or SSN _____

Group Number _____

Dental Insurance Carrier _____

Subscriber Employer _____

Subscriber Occupation _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Wilson & Wilson 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 hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Relationship _____ Date _____
 Responsible Party Signature

