



SONGBIRD DENTAL

555 Main Street, Suite 1-3, Shrewsbury, MA 01545
Tel: 508-842-8100, Fax: 508-842-4282

Family Account Information

Patient's Names:	Date of Birth:	Gender:
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

Date: _____

Name of Financially Responsible Person: _____
Last First MI

Social Security Number (Required): _____

Date of Birth: _____

Gender: Male Female

Family Status: Married Single Divorced Other

Address: _____
Street City State Zip Code

Phone Numbers: May we leave messages regarding treatment, appointments or billing at these numbers?

Home:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cell:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Work: ext:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

I understand that I am responsible for the cost of all dental treatment. I also understand that I am responsible for paying any copayments or deductibles that the insurance does not cover. I understand that I will be responsible for any fees if 3rd party collection efforts are required to collect a balance and for any returned check fees. I also understand that there will be a charge for any missed appointments or appointments with less than 24 hours notice to Songbird Dental.

Signature of Person Financially Responsible: _____

Date: _____

Primary Dental Insurance:

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Subscriber ID #: _____ Group #: _____
(Required)

Employer: _____

Name and State of Insurance Company: _____

I herby authorize release of any information including diagnosis and records of treatment of examination to my insurance company.

Signature: _____ Date: _____

Secondary Dental Insurance:

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Subscriber ID #: _____ Group #: _____
(Required)

Employer: _____

Name and State of Insurance Company: _____

I herby authorize release of any information including diagnosis and records of treatment of examination to my insurance company.

Signature: _____ Date: _____