

STUTLER DENTAL CARE
1460 N. Green St, Suite 100
Brownsburg IN 46112

Thank you for visiting Stutler Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form front and back.

Patient Information

Name _____
Last First Middle Nickname

Address _____
Street City Zip

Email Address _____ May we confirm appts by Email? yes no
May we confirm by text? yes no

Date of Birth _____ Height _____ Weight _____ SS# _____

Phone #: Hm _____ Work _____ Cell _____
May we contact you at work? Yes no

Emergency Contact _____ # _____ Relationship _____

Insurance Information

Primary Dental Carrier

Subscriber Name _____ SS# _____
Date of Birth _____ Employer _____
Insurance Name _____ Insurance Phone # _____
ID# _____ Group # _____
Relationship to Patient _____

Secondary Dental Carrier

Subscriber Name _____ SS# _____
Date of Birth _____ Employer _____
Insurance Name _____ Insurance Phone # _____
ID# _____ Group # _____
Relationship to Patient _____

Insurance Authorization Statement

I hereby authorize payment directly to the dental office of the group benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Patient Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relationship to Patient _____
Phone # _____