1601 S. Dishman Mica Road
Spokane Valley, WA 99206
(509) 924-1314

Patient Name _____ Name you wish to be called _____

Home Address _____ Home Phone _____

City _____State_____Zip Code_____ Work Phone _____

Mailing Address If Different _____ Cell Phone _____

City _____State_____ Zip Code_____ E-Mail _____

Best Time and Place to Reach You _____

Sex: ☐M ☐ F Age _____ Birthdate _____ Patient SS#_____

Occupation _____Employer _____

Employer Address _____ Employer Phone _____

Spouse/Parent Name _____ Birthdate _____ SS#_____

Occupation _____Spouse/Parent Employer _____Employer Phone_____

Emergency Contact (someone not living with you) _____ Relationship to you _____

Address and Phone Number of Emergency Contact Person _____

INSURANCE

Primary Coverage	Secondary Coverage
Employer _____	Employer _____
Insurance Co. _____	Insurance Co. _____
Insured Name _____	Insured Name _____
Birthdate _____	Birthdate _____
Group/Policy# _____	Group/Policy# _____
SS#/ID# _____	SS#/ID#_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Coulter Family Dentistry, 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 doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Relationship_____**Date**_____