UNKENHOLZ Family Dental

716 Quincy St.
Rapid City, SD 57701
605-399-9000
www.unkenholzfamilydental.com

Welcome To Unkenholz Family Dental!

Patient Information Confidential

Name_____ **Birthdate**_____
First MI Last

Address_____ **City**_____ **State**_____

Zip Code_____**Phone#**_____**Cell#**_____**Email:**_____

Preferred method of contacting (check all that apply): _____**Home** _____**Cell** _____ **Email**

SS# _____(Needed to file insurance) **Married** _____ **Single** _____ **Other** _____

Employer_____ **Work #**_____

Name of Person Responsible for account_____**Relationship**_____
(patient, parent of minor, guardian, spouse)

Address_____ **City**_____**State**_____

Birthdate_____ **SS#**_____

Phone #_____ **Cell #** _____ **Work#**_____

Person to contact in case of emergency_____ **Phone #**_____

How did you find out about our office?_____

INSURANCE INFORMATION

Name of Insured_____ **Relationship to patient**_____

Birthdate_____ **SS#**_____ **Date employed**_____
(Needed to file insurance)

Name of Employer_____ **Group #**_____

Insurance Company_____ **Policy #**_____

Insurance Address_____ **Insurance Phone#**_____

Do You Have Secondary Insurance? No_____ **Yes**_____**Name**_____

The undersigned, hereby authorize the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information.

Signature_____ **Date**_____