PATIENT INFORMATION

NAME _____

ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ HOME PHONE (_____) _____ CELL PHONE (_____) _____

SEX	BIRTH DATE	MARITAL STATUS	WEIGHT	HEIGHT
❑ M ❑ F	M / D / Y	❑ S ❑ M ❑ W ❑ D		

EMPLOYER'S NAME _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ BUSINESS PHONE _____

SOCIAL SECURITY NUMBER _____ WHICH DOCTOR DO YOU SEE? _____

PARTY RESPONSIBLE FOR ACCOUNT

NAME _____ HOME PHONE _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____ BUSINESS PHONE _____

DENTAL INSURANCE

INSURED PARTY _____ SS# OF INSURED _____

PLACE OF EMPLOYMENT _____ DOB OF INSURED _____

CARRIER _____ POLICY NO. _____

SEND CLAIMS TO _____

OTHER

PREVIOUS DENTIST'S NAME & ADDRESS _____

PHYSICIAN'S NAME & ADDRESS _____

IN CASE OF EMERGENCY NOTIFY NAME _____

RELATIONSHIP TO PATIENT _____ PHONE NO(S) _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

I authorize the release of any information necessary to process my insurance claim.

X _____

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

X _____