PATIENT INFORMATION FORM

Patient

Last Name__________________________ First Name______________________________MI_________

Address_______________________________________City________________State________ Zip________

Home Phone ____________________Work_____________________Cell____________________________

Date of Birth____________________________ Sex: Male ( ) Female ( )

Minor ( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated ( )

Person Responsible for Account

Last Name____________________________First Name______________________________MI_________

Address___________________________________City____________________State________ Zip________

Spouse

Last Name_______________________First Name___________________Employer___________________

Dental Insurance

Primary Insurance Company____

Subscriber Name______________________Group #______________Member #______________________

Employer____

Secondary or Medical (Circle One) **Insurance**

Primary Insurance Company____

Subscriber Name______________________Group #______________Member #______________________

Employer____

How did you hear about our office?____

Has any immediate family member been in our office? _____________ **Who?**__________________________

I hereby authorize release of any information, including the diagnosis and records of treatment or examinations rendered, to my insurance company or companies. I also authorize payment directly to the doctor, of insurance benefits to which I am entitled

Signature____ **Date**__________________________