PATIENT INFORMATION

____

Last Name First Name Middle Name DOB

PATIENT INFORMATION

Social Security #:_______________________________

Home Address: ____

City: ____ State: _____________________ Zip: ________________________

Cell Phone: ____ Home Phone: ____

Work Phone: _______________________________________ Other Phone: ____

Email Address: ____

Marital Status: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient/Guardian's Employer: ____________________________________ Occupation: ___________________________________

Spouse/Guardian's Name: _______________________________________ Contact Number: _______________________________

RESPONSIBLE PARTY **[ ]** Same as above

Name of Person Responsible for Account: ____ Relationship: ___________________

Social Security #: ___________________________________ Driver's License #: _____________________ DOB: _________________

Home Address: ____

City: ____ State: ____________________________ Zip: __________________

Cell Phone: ____ Home Phone: ____

Work Phone: ____ Other Phone: ____

Email Address: ____

INSURANCE INFORMATION

Name of Insured: ____ Relationship to Patient: _______________________________

Policy Holder's DOB: ____ Social Security #: ___________________________________

Policy Holder's Employer: ____________________________________ Work Phone: ____

Insurance Co.: ___________________________________ Group #: ______________________ Policy/ID#: ______________________

Do you have any additional dental insurance? [ ] Yes [ ] No

Whom may we thank for referring you? ____

Emergency Contact: ____ Phone: ____

Authorization and Release of Information

I agree that Erbeck Family Dentistry may bill my insurance carrier for the service provided, as a courtesy to me, and that all payments will come directly to Steven Erbeck, DDS or Bradley Erbeck, DDS at Erbeck Family Dental Company. I understand that I am solely responsible for the cost of my dental treatment. I hereby give authorization for the release of any information requested/required by my insurance company with respect to any insurance claims.

Patient/Guardian Signature: ____ Date: _______________________________