PATIENTS' INFORMATION SHEET

Please print clearly.

PATIENT INFORMATION

Name (*Last, First, MI):*

Date of Birth: **Age**: **Sex**: Male / Female **Marital Status**: S M W D

Address:

City: **State**: **Zip**:

Phone #: ( ) - **SS #**: - -

Cell Phone #: **EMAIL Address**:

Employer: Work #:

Referring Dental/Physician: If Student, School Name: Full / Part Time

RESPONSIBLE PARTY AND/OR SPOUSE INFORMATION

Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

Name: Relationship to Patient:

Address:

Phone #: ( ) - SS #: - - DOB: / /

Cell Phone #: Work #:

Employer:

Dental Insurance Co: ID#: Group #:

Medical Insurance Co: ID#: Group #:

Name of Spouse: SS #: - - DOB: / /

Spouse's Employer: Work #:

Dental Insurance Co: ID#: Group#:

Medical Insurance Co: ID#: Group #:

ADDITIONAL INSURANCE INFORMATION

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE INFORMATION

Name:	Relationship to Patient:	
Address:		
Phone #: ( ) -	SS #: - -	DOB: / /
Employer:	Work #:	
Dental Insurance Co:	ID#:	Group #:
Medical Insurance Co:	ID#:	Group #:

I hereby assign, transfer, and set over to **BRET A. AVRA, DMD, PSC** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Responsible Party Signature: Date: