Szabo Family Dentistry

Patient Information

Date_____

Name_____ I prefer to be called_____ Birthdate ____/____/_____Age_____

Address_____ City_____ State_____ Zip_____

Phone: Home (_____)_____ Work (_____)_____Ext_____ Cell (_____)_____

E-Mail_____ ☐ Male ☐ Female SSN _____

What is the best way to contact you during the day? ☐ Home phone ☐ Work phone ☐ Cell phone ☐ E-Mail

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If patient is a student name of school/college_____ Grade / Year_____

Employer_____Occupation_____ How long there?_____

Employer's Address_____

Person to contact in case of Emergency_____ Relation_____

Daytime phone_____ Cell Phone_____

How did you hear of our office?_____ Whom may we thank for referring you?_____

Other family members seen by us_____

Responsible party (If different from above)

Name_____ Relation to patient_____ SSN_____

Address_____ City_____ State_____ Z-p_____

Phone: Home (____)_____ Work (____)_____ Ext_____ Employer_____

Primary Dental Insurance Information

Insurance Company Name_____ Address_____

Phone# _____ Insured's Employer _____ Group/Plan # _____

Insured's Name _____ Relation _____ Insured's birthdate_____ Insured's SSN_____

Secondary Dental Insurance Information

Insurance Company Name_____ Address_____

Phone# _____ Insured's Employer _____ Group/Plan # _____

Insured's Name _____ Relation _____ Insured's birthdate_____ Insured's SSN_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed carrier(s) and assign directly to Szabo Family Dentistry PC all insurance benefits, if any, other wise payable to me for services rendered. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Responsible Party Signature Relationship Date