

# PATIENT INFORMATION



(PLEASE PRINT)

Patient's Name: \_\_\_\_\_  
Last First MI Preferred Name

Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

If patient is a minor, give parent's or guardian's name and phone #: \_\_\_\_\_

Home Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers Lic. #: \_\_\_\_\_

Marital Status: \_\_\_\_Married \_\_\_\_Single \_\_\_\_Male \_\_\_\_Female

Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Work Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Is an immediate family member a patient here? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## RESPONSIBLE PARTY

Self: \_\_\_\_ If other, Name: \_\_\_\_\_

If other, please complete...

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Relationship to Patient: \_\_\_\_\_

If different from above please fill out the following...

Address: \_\_\_\_\_

Home Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_

### Insurance Information

Insured Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Insured Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Ph.: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

## AUTHORIZATION

### Initials

- \_\_\_\_ 1. I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group insurance benefits directly to Tammy Weyandt D.D.S. and/or Anna Willison, D.D.S.
- \_\_\_\_ 2. I understand that my insurance co. may pay less than the actual bill for services and that I am fully responsible for payment of my account.
- \_\_\_\_ 3. I give consent to Tammy Weyandt D.D.S. and/or Anna Willison, D.D.S. to perform necessary procedures to diagnose, treat and care for the dental needs for my child and/or myself.
- \_\_\_\_ 4. Parent or legal guardian must be present for dental visits of children under the age of 18.
- \_\_\_\_ 5. In order to give your child our full attention we request that you remain in the reception area.
- \_\_\_\_ 6. If your child is not cooperative we may suggest referral to a pediatric specialist. However, you will be charged an office visit fee for the time spent with your child.

I certify that the information I have provided here is accurate

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_