Date: ____________________

PATIENT INFORMATION

Patient's Name : ____
LAST FIRST MIDDLE

If patient is a minor, parent's or guardian's name: ________________________________

Patient's Birthdate: ____________________ Patient's Social Security #: ____________________

Whom may we thank for referring you to our office? ________________________________

RESPONSIBLE PARTY INFORMATION

Name: ____ ____________
LAST FIRST MIDDLE MARITAL STATUS

Address : ____
STREET CITY STATE ZIP

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Social Security #: ____________ Birthdate: ____________ Relationship to patient: ____________

Email address: ____

Employer: ________________________ Occupation: ________________________

Spouse's Name: ________________________________ Relationship to patient: ____________
LAST FIRST MIDDLE

Employer: ________________________ Occupation: ________________________

Social Security #: ____________ Birthdate: ____________ Phone: ____________

INSURANCE INFORMATION

Insured's Name: ________________________ Insured's Social Security #: ____________

Insurance Company: ________________________ Group Number: ____________

Insurance Company Address: ____

Do you have dual coverage? _____ Yes _____ No If yes:

Insured's Name: ________________________ Insured's Social Security #: ____________

Insurance Company: ________________________ Group Number: ____________

Insurance Company Address: ____

Insured's Employer: ____

EMERGENCY INFORMATION

Emergency Contact: ________________________________ Phone: ____________

Address: ____

I understand the responsibility for payment for services provided in this office is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand a finance charge will be added to any outstanding balance of 60 days. I also hereby assign any insurance benefits to Ben T. Grieb, D.M.D.

Signature (parent/guardian signature if minor): ____