PATIENT INFORMATION

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____ BIRTHDATE _____
MONTH DAY YEAR

ADDRESS _____
STREET APT# CITY STATE ZIP

TELEPHONE _____ _____ _____
HOME WORK CELL

EMAIL ADDRESS _____

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS – COMPLETE PRIMARY INSURED
DUAL COVERAGE – ALSO COMPLETE THE SECONDARY INSURED

PRIMARY INSURED – IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME WORK CELL EMAIL

_____
BIRTHDATE (MO/DAY/YR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INSURANCE CO.

_____
SS# SUBSCRIBER# GROUP#

SECONDARY INSURED

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

_____
HOME WORK CELL EMAIL

_____
BIRTHDATE (MO/DAY/YR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INSURANCE CO.

_____
SS# SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY NAME _____

ADDRESS_____ PHONE #_____

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

Has any member of your family ever been treated in our office? ☐ Yes ☐ No

AUTHORIZATION

I hereby authorize payment directly to Dr. Van Zytveld of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Van Zytveld to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____ _____

Patient or Responsible Party State Driver's License Number

_____

Date

METHOD OF PAYMENT

Does responsible party currently have an account with this office? ☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

☐ I wish to discuss the Dental Office's Financial Policy