# CONFIDENTIAL PATIENT INFORMATION

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|---|---|---|---|---|---|---|---|
| PATIENT'S NAME | LAST | FIRST | MIDDLE | DATE OF BIRTH | | SEX | SOCIAL SECURTY # |
| ADDRESS | STREET | APT# | CITY | STATE ZIP | EMAIL | | HOME# |
| MARITAL STATUS<br>□M □S □D □W | | PATIENT'S/GUARDIANS EMPLOYER | | | | OCCUPATION | |
| WORK ADDRESS | STREET | CITY | STATE ZIP | CELL # | WORK # | | OK TO CALL WORK<br>□ YES □ NO |
| SPOUSE'S NAME | LAST | FIRST | MIDDLE | SPOUSE'SEMPLOYER | | OCCUPATION | |
| WORK ADDRESS | STREET | CITY | STATE ZIP | CELL # | WORK # | | OK TO CALL WORK<br>□ YES □ NO |
| PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)<br>NAME RELATIONSHIP HOME# WORK# CELL# | | | | | | | |
| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | | | | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE | | | |

# DENTAL INSURANCE INFORMATION

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| **PRIMARY COVERAGE**<br>□ YES □ NO | INSURANCE COMPANY NAME | ADDRESS | PHONE |
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>□ SELF □ SPOUSE □DEPENDENT | SUBSCRIBER DATE OF BIRTH | SUBSCRIBER'S SSN# |
| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | |

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|---|---|---|---|
| **SECONDARY COVERAGE**<br>□ YES □ NO | INSURANCE COMPANY NAME | ADDRESS | PHONE |
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>□ SELF □ SPOUSE □DEPENDENT | SUBSCRIBER DATE OF BIRTH | SUBSCRIBER'S SSN# |
| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | |

## ASSIGNMENT & RELEASE:

- I hereby authorize my insurance benefits to be paid directly to the dentist, Dr. Ken Schweifler. I am financially responsible for any co-pays, co-insurance or balances not covered by my dental insurance benefits at the time service is rendered. I authorize the dentist to release any necessary information for future dental claims to be processed.
- I authorize that my records can be used by the doctor if he so determines.
- In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.
- I consent to the making of videotapes, photographs, and x-rays before, during and after treatment, and to the use of same by the doctor/dentist in scientific papers or demonstrations.
- I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date: _____