Date________________Referred by____

Ms/Mr/Dr Last name______________________First_____________________Middle_________

Address:________________________________City:________________State:______Zip_______

Phone #: (H)_________________(W)_________________(C)________________ Sex: F M

SS#:_______________________ Marital Status: S M W D Birthdate:________________

Email: ___________________________________Occupation: ____________________________

Employer:____

Work address:___________________________City:________________State:_____Zip_______

Spouse/Parent's name:______________________________Work phone:_____________________

(Please circle) First Last

Present Dentist:___________________________Phone:___________________________________

Address:____

INSURANCE INFORMATION

DENTAL INSURANCE:

Insured's name________________________________ Insured's SS#_______________________

Insured's DOB____/____/____ Relationship to Patient__________________________________

Insured's employer____

Insurance carrier_____________________________Address______________________________

Phone #_____________________Policy#_____________________Group #___________________

SECONDARY DENTAL INSURANCE (if applicable):

Insured's name________________________________ Insured's SS#_______________________

Insured's DOB____/____/____ Relationship to Patient _________________________________

Insured's employer____

Insurance carrier_____________________________Address______________________________

Phone #_____________________Policy#_____________________Group #___________________

PATIENT RELEASE FORM

I authorize Frederick Periodontal Assoc. to release any information requested by my third party payor regarding charges incurred by this patient. In addition, I authorize the use of this signature on all insurance submissions.

Signature______________________________________**Date**__________________________

(circle one: Patient / Parent or Legal guardian)