

Please complete this form by clearly printing all information so we may enter it into our computer system.

PATIENT INFORMATION

Date: _____ Referred By: _____ Title: Ms./ Mrs./ Mr./ Dr.
 Name: Last: _____ First: _____ Middle Initial: _____
 Spouse/Parent/ Guardian Name (please circle if applicable): _____
 If military, what is your rank or title? _____ Sex: F M Marital Status: S / M / W / D
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Numbers: (H) _____ (W) _____ (C) _____
 SS#: _____ Birth Date: _____ Email: _____
 Present Dentist: _____ Occupation: _____
 Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

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 #: _____

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)