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)