



## PATIENT INFORMATION SHEET

PATIENT NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ AGE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ SEX (M/F) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

HOME# \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_

EMPLOYER \_\_\_\_\_

OCCUPATION (IF RETIRED, FORMER OCCUPATION) \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_

MOTHER/FATHER NAME (IF PATIENT IS A MINOR) \_\_\_\_\_

TO WHOM SHALL STATEMENTS BE SENT (IF OTHER THAN PATIENT)? \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM PATIENT) \_\_\_\_\_

### CONTACT PERSON IN CASE OF EMERGENCY:

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

METHOD OF PAYMENT: CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CREDIT CARD \_\_\_\_\_

### REFERRAL INFORMATION

NAME OF PERSON OR OFFICE REFERRING YOU TO OUR PRACTICE: \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

**PRIMARY DENTAL INSURANCE** \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_

**SECONDARY DENTAL INSURANCE** \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ASSIGN DIRECTLY TO DUCK FAMILY DENTAL ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AGREE TO PAY ALL COLLECTION COSTS, COURT COSTS, AND ATTORNEY FEES IF ACCOUNT IS TURNED OVER TO COLLECTIONS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_