PATIENT INFORMATION:

NAME (Last, First, M.I.)_____

ADDRESS_____CITY_____STATE_____ZIPCODE_____

TELEPHONE NUMBER: HOME_____CELL_____WORK_____

E-MAIL ADDRESS:_____ *MAY WE CONFIRM BY E-MAIL OR TEXT?_____*

BIRTHDATE_____/_____/_____ AGE_____ SOCIAL SECURITY # _____/_____/_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY, NAME_____#_____

PATIENT STATUS: *MARRIED___ SINGLE ___ WIDOWED___ OTHER ___ LEGALLY SEPERATED___ DIVORCED___*

EMPLOYMENT STATUS: *EMPLOYED, FULL TIME___ EMPLOYED, PART TIME___ RETIRED____ NOT EMPLOYED ___ STUDENT, FULL TIME___ STUDENT, PART TIME____*

EMPLOYERS NAME_____

ADDRESS & NUMBER_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

RESPONSIBLE PARTY FOR INSURANCE:

NAME (Last, First, M.I.)_____

ADDRESS_____CITY_____STATE_____ZIPCODE_____

TELEPHONE NUMBER: HOME_____CELL_____WORK_____

BIRTHDATE_____/_____/_____ AGE_____ SOCIAL SECURITY # _____/_____/_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY_____

POLICY HOLDERS NAME _____DATE OF BIRTH_____ GROUP#_____

INSURED EMPLOYER'S NAME_____PHONE NUMBER_____

SECONDARY INSURANCE COMPANY _____

POLICY HOLDERS NAME _____DATE OF BIRTH_____ GROUP#_____

OTHER FAMILY MEMBERS SEEN IN OUR OFFICE_____

ASSIGNMENT AND RELEASE:

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. MARK J. FLEMING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NONCOVERED SERVICES. I ALSO AUTHORIZE DR. MARK J. FLEMING TO RELEASE ANY INFORMATION REQUIRED TO PROCESS ANY AND ALL MY DENTAL CLAIMS.

SIGNED:_____ DATE ____/____/_____