PATIENT INFORMATION

Patient's Name _____
Last First Middle

Address _____ Apt. # _____

Address _____ _____ _____
City State Zip

Phone#'s
Home _____ Cell _____ Work _____

Email Address _____ Male ___ Female ___ Age _____

Date of Birth _____ Soc. Sec. # _____

___ Married ___ Widowed ___ Single ___ Child ___ Separated ___ Divorced Full-Time Student: YES ____ NO ____

Occupation_____ Employer/School Name _____

Who is responsible for account? _____ Relationship to Patient _____

Who should we thank for referring you? _____

DENTAL INSURANCE

Primary Insurance _____ Subscriber _____

Subscriber ID# _____ Group # _____ DOB _____

Secondary Insurance _____ Subscriber _____

Subscriber ID# _____ Group # _____ DOB _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with _____
And assign directly to Klein, Begnoche, and Tumminia Dental, P.A. all insurance benefits, if payable by insurance. I authorize the use of my signature on all insurance submissions. Klein, Begnoche, & Tumminia Dental, P.A. may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, or Guardian Date

Relationship to Patient _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone_____

Todays Date _____