PATIENT AND INSURANCE INFORMATION

NAME____TODAYS DATE__________

Nickname_______________E-mail_________________________DATE OF BIRTH_________

HOME ADDRESS____

HOME PHONE____________________ WORK PHONE___________________

OTHER PHONE OR PAGER________________ SOCIAL SECURITY#________________

BEST TIME AND PLACE TO REACH YOU____ DRIVERS LIC #_____________________

CIRCLE APPROPRIATELY: MINOR SINGLE MARRIED OTHER

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE_________________________

HOW DID YOU HEAR ABOUT US? WORD OF MOUTH PHONE BOOK INSURANCE

IN CASE OF AN EMERGENCY CONTACT____

NAME_______________________RELATIONSHIP________________PHONE#__________

PERSON RESPONSIBLE FOR THIS ACCOUNT:

NAME_______________________ADDRESS_______________________________________

EMPLOYER__________________ADDRESS_______________________________________

DENTAL INSURANCE INFORMATION

(PLEASE HAVE YOUR INSURANCE CARD READY FOR PHOTOCOPYING)

DENTAL INSURANCE CO.____

SUBSCRIBER'S NAME_____________________________GROUP#______________________

S.S.#____BIRTHDATE__________________

DO YOU HAVE ANY ADDITIONAL INSURANCE?____YES___NO IF YES PLEASE LIST ___

ASSIGNMENT & RELEASE

I, THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH
AND ASSIGN DIRECTLY TO DR. ROBERTO SANTIAGO 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, INCLUDING ATTORNEY FEES AND COSTS REQUIRED FOR COLLECTION. I HEREBY AUTHORIZE DR. SANTIAGO TO RELEASE INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON INSURANCE SUBMISSIONS.

SIGNATURE____DATE_______________