

Patient's Name: _____ Preferred Name: _____

(Last) (First) (MI)

Status: Married Single Minor Gender: Male Female

Date of Birth: _____ Social Security # _____ Parent/Guardian (If Minor) _____

Address: _____
(Street) (City) (State) (Zip)

Home #: _____ Cell #: _____ Work #: _____ Employer: _____

Email: _____ Do you work in uptown? Yes No

Emergency Contact: _____ Preferred appointment time: Morning Afternoon

Relationship: Parent Spouse Family Friend Other Preferred appointment day: M T W Th F

Phone #: _____

Primary Dental Information

Secondary Dental Information

Insurance Co. _____

Insurance Co. _____

Insurance phone # _____

Insurance phone # _____

Employer: _____

Employer: _____

Group Number: _____

Group Number: _____

Subscriber ID or SS # _____

Subscriber ID or SS # _____

Subscriber Name: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Date of Birth: _____

I authorize payment directly to Dr. Gordon J. Roznik, of insurance benefits otherwise payable to me. I understand that my dental insurance or carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

Patient / Guardian Signature: _____ **Date:** _____

To the best of my knowledge, all of the information provided above is true and correct.

Date _____

Patient / Guardian Signature

Whom may we thank for referring you to our practice?

Yellow Pages Direct Mail Radio Other _____
 Word of Mouth Internet Walk-In Another Patient _____