PATIENT INFORMATION

Patient Name ________________________________Prefer to be addressed as _________________________

Birthdate_____________Sex _______Marital Status_________SSN_____________

Home address____

City/State_____________________________Zip__________________Home phone_____________________

Employer_____________________________Work phone__________________May we call you at work?____

Email address__________________________ Cell Phone___________________

Preferred method of contact: Home phone _____ Work phone _____ Email ______ Cell phone _____

Student_______Where?_______________ Whom may we thank for this referral?________________________

Nearest relative *not living with you*__________________relationship____________phone #________________

Guarantor (if not same as above) - Please note: we cannot bill a non-custodial parent
Name____Relationship_____________________

Birthdate_____________SSN #______________

Billing Address____

City/State_____________________________Zip__________________Home phone#____________________

Employer_____________________________Work phone__________________May we call you at work?____

Insurance	**Primary**	**Secondary**
Insurance Co. Name	________________________	________________________
Billing Address	________________________	________________________
Telephone	________________________	________________________
Group #	________________________	________________________
Policyholder’s name	________________________	________________________
Policyholders SS #	________________________	________________________
Relationship to Patient	________________________	________________________
Policyholder’s Birthdate	________________________	________________________
Policyholder’s Employer	________________________	________________________

I hereby authorize Dr. Cobble to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature ____________________________________ Date ____________________
Policyholder Signature ____________________________________ Date ____________________