Michael Horan, DDS Julie Becker, DDS Bryan Darling, DDS, MD

PATIENT INFORMATION

DATE _____

Name (First & Last) _____ Nickname_____

SSN _____ Date of Birth _____ Sex: M F UNSPECIFIED (please circle one)

Address _____ City_____ State _____ Zip _____

Telephone: Home (_____)_____ Cell (_____)_____

Email Address: _____

Dentist's Name _____ Physician's Name_____

Whom shall we thank for referring you to us? _____

Name of Person driving you home _____

PERSON RESPONSIBLE FOR ACCOUNT OR IF PATIENT IS UNDER THE AGE OF 18 PLEASE COMPLETE THE FOLLOWING

Person Responsible for account _____ DOB _____

SSN_____ Relationship to Patient: Spouse Parent Other

Address _____ City_____ State _____ Zip_____

Telephone: Home (____)_____ Cell(____)_____

PRIMARY DENTAL INSURANCE

Insurance Company:_____ Employer:_____

ID #:_____ Group #:_____

Name of policy holder: _____ DOB: _____ SSN:_____

Relationship to patient: Self Spouse Parent Other

SECONDARY DENTAL INSURANCE

Insurance Company:_____ Employer:_____

ID #:_____ Group #:_____

Name of policy holder: _____ DOB: _____ SSN:_____

Relationship to patient: Self Spouse Parent Other

METHOD OF PAYMENT TODAY (PLEASE CIRCLE ONE)

CASH CREDIT/DEBIT CARD CARE CREDIT CHECK

****Cardholder/account holder must be present & will need to provide proof of ID****

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. A copy of our Privacy Policy is available upon request. I agree to permit Horan, Becker and Darling D.D.S and their business associates to contact me, and all other responsible parties on my account concerning any and all aspects of my account.

_____ _____ _____

Signature of patient; parent, guardian/guarantor/responsible party Relationship Date

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PRIMARY MEDICAL INSURANCE

Insurance Company:_____ Employer:_____

ID #:_____ Group #:_____

Name of policy holder: _____ DOB: _____ SSN:_____

Relationship to patient: Self Spouse Parent Other

SECONDARY MEDICAL INSURANCE

Insurance Company:_____ Employer:_____

ID #:_____ Group #:_____

Name of policy holder: _____ DOB: _____ SSN:_____

Relationship to patient: Self Spouse Parent Other

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