WARNER FAMILY DENTISTRY PATIENT INFORMATION FORM

Patient Name: First_____MI_____Last_____ Marital status:_____
Home address:_____City:_____State:_____Zip:_____
Billing address (if different):_____
Sex (M/F):_____ Date of birth:_____ Age:_____ SS#:_____
Home phone:_____Cell phone:_____E-mail:_____
Employer:_____Occupation:_____Work phone:_____
Address:_____City:_____State:_____Zip:_____
Emergency contact #:_____Relationship to patient:_____
Who may we thank for referring you to our office?_____

Head of family (for family records):_____Relationship to patient:_____
Spouse (if married)/**Parent** (if patient is a child):_____
Address:_____City:_____State:_____Zip:_____
Marital status:_____Home phone:_____Sex:_____DOB:_____SS#:_____
Employer:_____Work phone:_____
Address:_____ City:_____State:_____Zip:_____
Second parent (if patient is a child):_____
Address:_____City:_____State:_____Zip:_____
Marital status:_____Home phone:_____Sex:_____DOB:_____SS#:_____
Employer:_____Work phone:_____
Address:_____City:_____State:_____Zip:_____

***Authorization to release Protected Health Information to the following family members or friends when they verify patient information:**

1. _____ 2._____
3._____ 4._____

***Authorization to release Protected Health Information for dental insurance, Medicaid, or patient treatment. I understand that I am responsible for all costs of dental treatment.**

Signature:_____ Date:_____
(Patient, or Parent if patient is a minor) **ALL PATIENTS MUST SIGN THIS LINE**

Name of Insured:_____DOB:_____SS#:_____
Employer of insured:_____Address:_____
Insurance Company Name:_____Phone #:_____
Claims address:_____City:_____State:_____Zip:_____
ID#:_____Medicaid #:_____Group #:_____

***Authorization of payment to Dr. Lindsey H. Warner for group insurance benefits otherwise payable to me.**

Signature:_____ Date:_____
(Insured person or Patient)