NEW PATIENT INFORMATION

Last Name:_____First:_____

Preferred or Nickname:_____

Address:_____City:_____St:____Zip:_____

Home Phone:_____ Work Phone:_____ Cell phone:_____

SS#:_____Date of Birth:_____ Sex: M__ F__ Marital St:____

Email Address:_____

How do you prefer to be contacted:_____ Who may we thank for referring you?_____ Emerg. Contact:_____

Patient Employer/School:_____

PRIMARY INSURANCE COVERAGE (Please provide your card for our records):

Policy holders Name:_____SS#:_____DOB:_____

Member ID#_____ Group ID#_____

Insurance Company:_____ Employer Name:_____

SECONDARY INSURANCE COVERAGE: (if applicable)

Policy holders Name:_____SS#_____ DOB:_____

Member ID#:_____ Group ID#:_____

Insurance Company:_____ Employer Name:_____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company(ies) and assign directly to Dr. Karen Glerum 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. I authorize the use of all my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits of the benefits payable for related services.

Patient Signature:____Date:_______________