Patient Information Form

Name _____

Address _____

City _____ State _____ Zip Code _____

Preferred # ( ) _____ Email _____

Birth Date ___/____/___ Male [ ] Female [ ] Martial Status _____

Insurance Information

Primary Insurance _____

Group # _____ ID # _____

Subscriber _____ Employer _____

Birth Date ___/_____/_____ Soc. Security # _____

Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Other

Secondary Insurance _____

Group # _____ID # _____

Subscriber _____ Employer _____

Birth Date ___/_____/_____ Soc. Security # _____

Relationship to Patient [ ] Self [ ] Spouse [ ] Parent [ ] Other

****Emergency Contact**

Name _____ Phone # _____

Relationship to Patient _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Tiffin Family Dentistry. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature _____ Date ____/_____/_____