



Deland Implant Dentistry

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PATIENT INFORMATION [Confidential]

Name: _____ Today's Date: ___/___/___
 Address: _____ City _____ State: ___ Zip: _____
 Date of birth: ___/___/___ Home Phone: (___) ___ - _____ Cell Phone: (___) ___ - _____
 Check appropriate line: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___
 If college student, FT / PT, Name of School _____ City _____ State _____
 Patient's or Parent's employer: _____ Work Phone: (___) ___ - _____
 Business Address: _____ City _____ State: ___ Zip: _____
 Spouse Name or Parent's Name: _____ Employer: _____ Work Phone: (___) ___ - _____
 Whom may we thank for referring you? _____
 Person to contact in case of emergency: _____ Phone: (___) ___ - _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____
 Relationship To Patient: _____
 Address: _____
 Phone: (___) ___ - _____ Driver's License # _____ DOB: ___/___/___

INSURANCE INFORMATION

Name of Person Responsible for this Account: _____
 Relationship To Patient: _____ Date of Birth: ___/___/___
 Name of Employer: _____ Date Employed: ___/___/___
 Work Phone: (___) ___ - _____
 Employer Address: _____ City _____ State: ___ Zip: _____
 Insurance Company: _____ Phone: (___) ___ - _____ Group #: _____ Policy \ ID #: _____
 Ins. Co. Address: _____ City _____ State: ___ Zip: _____
 How much is you Deductible? _____ How much have you used? _____ Max annual Benefit? _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that I am required to pay in full for the treatment and services provided by Dr. Patel and/or his staff at the time of services and get reimbursed from my insurance company. I hereby authorize Dr. Patel to release any information necessary to secure the payment of benefits. I authorize use of this signature for all insurance submissions.

Signature of Patient/guardian or Parent if Minor

Relationship to patient

Date