

# STEPHEN FORREST, DDS & BRADLEY G. MARKOWSKI, DDS

## 1 PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Mr Mrs Ms Dr

I prefer to be called \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Home Address: (No P.O. Box) \_\_\_\_\_  
Apt/Condo #

\_\_\_\_\_  
City State Zip

Billing Address: (If different) \_\_\_\_\_  
Apt/Condo #

\_\_\_\_\_  
City State Zip

Single  Married  Divorced  Widowed  Separated

Hm #: \_\_\_\_\_ Cell / Other #: \_\_\_\_\_

Wk #: \_\_\_\_\_ Ext: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: (Required) \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_

## 2 SPOUSE/PARENT INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

**In the event of an emergency, whom should we contact?**

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: \_\_\_\_\_ Hm #: \_\_\_\_\_

## 3 DENTAL INSURANCE

### Primary Dental Insurance

Insured's Name: Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

### Secondary Dental Insurance

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

### Insurance Authorization

I authorize payment directly to the treating Dr. of all insurance benefits otherwise payable to me. I consent to the use and disclosure of my protected health information to carry out payment and insurance activities for claims made on my behalf. I permit a copy of this authorization to be used in place of the original unless revoked in writing.

Signature: \_\_\_\_\_

### Professional fees and billing.

Please read our office financial & insurance document.

I have received a copy of the Insurance, Financial and Office Policy document. I understand a 1.5% per month (18%/yr.) service charge will be added to outstanding balances aged 46+ days from initial service. I understand I am financially responsible for all services provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have received a copy of this office's HIPAA and privacy practices policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional copies may be requested at any time.

