PATIENT INFORMATION *(Please Print)*

Title _____ Name _____
Last First MI Nickname

Address_____City_____State_____Zip _____

Email Address_____

Home Phone_____ Work Phone_____ Cell Phone_____ CIRCLE BEST #

Social Security #_____ Birth date_____ Age _____

Employer_____ Occupation _____

Who is your general dentist? _____ How long? _____

Who may we thank for referring you?_____

Do you have any relatives that are patients here? _____ If so, who? _____

Person to contact in case of emergency_____ Phone _____

RESPONSIBLE PARTY INFORMATION *(If other than patient)*

Name_____ Relationship to Patient _____

Address_____City_____State_____Zip _____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____ Relationship to Patient _____

Subscriber's Address_____City_____State_____Zip _____

Social Security # or ID #_____ Birthdate _____

Name of Employer_____ Work Phone _____

Insurance Company_____ Group # _____

Billing Address_____City_____State_____Zip_____

Phone _____

RELEASE AND ASSIGNMENT *I hereby authorize Thomas J. Chapman DDS, PC to release to my insurance company or its representative any information and/or records of any treatment or examination rendered. I also authorize and request my insurance to directly pay Dr. Chapman the amount due for dental treatment or services.*

_____

Signature of Patient, Parent or Guardian Date

Thank you for taking the time to provide this information. Thomas J. Chapman, DDS _____