Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Information:

First Name:_____ Last Name: _____Middle Initial: _____

Preferred Name: _____ Date of Birth: _____

SS#/SIN: _____ Driver's License#: _____

Male☐ Female☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Address: _____ Address 2: _____

City/State/Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address: _____ Would you like to receive correspondences via email?: Y / N ☐☐

How did you hear about our practice?: _____

Employment Status: Full Time ☐ Part Time ☐ Retired ☐ Emergency Contact Name: _____

Student Status: Full Time ☐ Part Time ☐ Emergency Contact Phone Number: _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____

Responsible Party (if other than self)

Name: _____Relationship to Patient _____

Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

SS#/SIN: _____ Driver's License: _____

Authorization:

I authorize and give consent to Christopher R. Rebol, DDS to perform dental services agreed upon between doctor and patient (and/or parent or guardian) to be necessary or advisable including the use of local anesthesia and other medications as indicated. Payment of all treatment and services rendered are my responsibility. I understand payment is due at the same day services are rendered. I hereby authorize payment of insurance benefits, if applicable, otherwise payable to me directly to the doctor. I understand that the benefits explained to me are only estimates, and I am responsible for all costs for dental treatment not covered by my insurance. Remaining balances are to be paid in full by the responsible party.

Patient Signature _____ Date: _____

If patient is under 18 years of age or requires a guardian:

Parent / Guardian Signature _____Date: _____

Insurance Policy:

We do accept dental insurance and try to be familiar with the regulations and restrictions of each company and policy; however, due to the variety of plans available, the patient is ultimately responsible for understanding the details of their coverage. Dr. Rebol and his staff work for you, not an insurance company. We are happy to file your insurance for you and will work to maximize your benefits. However, we believe in the sanctity of the doctor-patient relationship and a treatment planning will always start with what is best for your long term health and not the bottom line of your insurance carrier. Please feel free to discuss any concerns you may have regarding your coverage with us.

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other

Birthdate: _____ SS/SIN: _____

Name of Insured Employer: _____ Work Phone: _____

Address of Insured Employer: _____

Insurance Company: _____ Group #: _____

Insurance Company Address: _____

How much is your deductible? _____ How much have you used? _____ Maximum Annual Benefit? _____

Do you have secondary insurance? If yes, please complete the following:

Name of Insured: _____ Relationship to Insured: ☐ Self / ☐ Spouse / ☐ Child / ☐ Other

Birthdate: _____ SS/SIN: _____

Name of Insured Employer: _____ Work Phone: _____

Address of Insured Employer: _____

Insurance Company: _____ Group #: _____

Insurance Company Address: _____

How much is your deductible? _____ How much have you used? _____ Maximum Annual Benefit? _____