PATIENT INFORMATION & INSURANCE DATA

Name____ D.O.B. ____/____/__________
First Middle Last Mo/Da/Year

Check One: Minor Single Married Divorced Separated S.S. # ____/____/__________

Residence Address ____
Street or P.O. Box # City State Zip

Residence Phone ________________ Business Phone ______________ May we contact you at work? Yes No

Cell Phone ____________________ E-Mail ____________________

Address where statement should be sent if different than above:

____

Name Address

Whom may we thank for referring you to us? Name ______________________________

Address ______________________________

City, State, Zip ______________________________

If you have dental insurance which may assist you with a portion of your account, please complete the following:

Employee______________________________ D.O.B.____/____/____S.S.#____/____/__________

Employer ______________________________ Insurance Co. ____________________

Position ______________________________ ____________________

Effective Date ______________________________ ____________________

____

Subscriber or Policy # ______________________________ Group or File # ________________

Relationship of Patient to Employee: (Check One:) Self Child Spouse Other ____________________

Additional Dental coverage? Yes No If yes, please complete this section also.

Employee______________________________ D.O.B.____/____/____S.S.#____/____/__________

Employer ______________________________ Insurance Co. ____________________

Position ______________________________ Insurance Co. Address ____________________

Effective Date ______________________________ ____________________

____

Subscriber or Policy # ______________________________ Group or File # ________________

Relationship of Patient to Employee: (Check One:) Self Child Spouse Other ____________________

MEDICAL COVERAGE:

Employee ____________________ D.O.B.____/____/____ S.S. #____/____/________

Employer ____________________ Insurance Co. ____________________

Effective Date ____________________

Subscriber or Policy #____________________ Group or File # ____________
Relationship of Patient to Employee: Check One: Self Child Spouse Other

Additional Medical Coverage? Yes No If yes, please complete this section also.

Employee ____________________ D.O.B.____/____/____ S.S. #____/____/________

Employer ____________________ Insurance Co. ____________________

Effective Date ____________________

Subscriber or Policy #____________________ Group or File # ____________
Relationship of Patient to Employee: Check One: Self Child Spouse Other

MINOR CHILD RELEASE

I give my permission to Dr. Tom A. Stamas and/or his designated assistant to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics, on my minor child(ren),____________________, whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible for all treatment rendered to the above-named child(ren).

Signed ____________________ Date ____________________

SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____________________ HEREBY AUTHORIZE ____________________ TO PAY
(Name of insured) (Name of company)

and hereby assign directly to Dr. Tom A. Stamas, all dental benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Dr. Tom A. Stamas. Authorization is hereby given to release all information necessary to the payment of said benefits.

____
(AUTHORIZED SIGNATURE OF COVERED PERSON/EMPLOYEE)

____
(DATE)