CONFIDENTIAL PATIENT INFORMATION

Patient's name: ______________________________ Date: ____________

Birth Date: _______________ SS#: _________________ Age: _____ Marital Status: __________

Address: ______________________________ City, State, Zip: ____________________

Home Phone: (_____)_______________ Work Phone: (_____)_______________ ext______

Cell Phone: (_____)_______________ Pager #: (_____)_______________

In case of emergency, I give permission to notify: ______________________ and disclose vital information. Phone: (_____)_______________

E-MAIL ADDRESS: ____

MEDICAL INSURANCE

Responsible Party: ______________________ Relation to Patient: ____________________

Birth Date: _______________ SS#: _______________

Employer: ______________________________ Employer Phone: (_____)_______________

Insurance Company: ____

Is patient covered by additional insurance? Yes ☐ No ☐

DENTAL INSURANCE

Responsible Party: ______________________ Relation to Patient: ____________________

Birth Date: _______________ SS#: ___________________

Employer: ______________________________ Employer Phone: (_____)_______________

Insurance Company: ____

Is patient covered by additional insurance? Yes ☐ No ☐

ADDITIONAL INFORMATION

Whom may we thank for referring you?: ______________________________

Name of your primary care physician: ____________________ Name of your dentist: ____________________

AUTHORIZATION

I authorize my insurance company to pay Dr. Leland S. Blough, Jr., D.M.D all insurance benefit otherwise payable to me for services rendered.
I authorize the use of this signature on all submissions.
I authorize Dr. Leland S. Blough, Jr., D.M.D. to release all information necessary to secure the payment of benefits.
I understand that professional services are rendered and charged to the patient and not the insurance company.
I am financially responsible for all charges whether or not paid by insurance.
If I do not pay my bill and my bill goes to a collection agency, a 33% charge will be added on to my balance.

Signature: ______________________________ Date: ____________________

•Payment is expected at the time of treatment.

*** PLEASE COMPLETE BOTH SIDES OF THIS FORM ***

If you are on Fosamax or similar medications for osteoporosis, inform the doctor and staff.