

PERSONAL HISTORY

Patient

Name: _____
 Address: _____
 City:State:Zip _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Employer: _____
 Address: _____
 City: _____
 Social Security No.: _____
 Date of Birth: _____
 E-Mail Address: _____

Person Responsible for Account

Name: _____
 Address: _____
 City: _____
 Home Phone: _____
 Work Phone: _____
 Date of Birth: _____
 Employer: _____
 Address: _____
 City: _____
 Social Security No.: _____
 Whom may we thank for referring you?
 Name: _____

Circle One: Married Single Child

INSURANCE INFORMATION

	First Insurance Co.	Second Insurance Co. (If covered by more than one insurance)
Employee's Name	_____	_____
Employee's Social Security No.	_____	_____
Employee's Gender	_____	_____
Employee's Date of Birth	_____	_____
Insurance Co. Name	_____	_____
Insurance Co. Address	_____	_____
City, State, zip	_____	_____
Group Plan Number	_____	_____
Local Union Number	_____	_____
Policy No. (or P.O.E. No.)	_____	_____
Employer's Name	_____	_____
Employer's Address	_____	_____
City	_____	_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependant(s), have insurance coverage with the above named Insurance Co. and assign directly to Dr. Bruce Grbach, DDS, Inc. all insured benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Bruce Grbach, DDS, Inc. may use my health care information and may disclose such information to the above-named Insurance Compan(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

 Signature of patient, parent or guardian

Date _____