

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Phone#'s Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
\_\_\_ Married \_\_\_ Widowed \_\_\_ Single \_\_\_ Child \_\_\_ Separated \_\_\_ Divorced Full-Time Student: YES \_\_\_ NO \_\_\_

Occupation \_\_\_\_\_ Employer/School Name \_\_\_\_\_

Who is responsible for account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

### DENTAL INSURANCE

Primary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_ DOB \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
And assign directly to Klein, Begnoche, and Tumminia Dental, P.A. all insurance benefits, if payable by insurance. I authorize the use of my signature on all insurance submissions. Klein, Begnoche, & Tumminia Dental, P.A. may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, or Guardian

\_\_\_\_\_  
Date

Relationship to Patient \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Today's Date \_\_\_\_\_

