Welcome to Our Practice

CONFIDENTIAL PATIENT INFORMATION

Donna L. Kalil, D.M.D. *Beth A. Kress, D.D.S.*
Justine R. Kelley, D.M.D *Edmund J. Telage, D.D.S.*

Date:_____

Patient Name:_____ **Date of Birth**: / /
Last First Middle Initial

SSN:_____

Title: [ ]Mr. [ ]Mrs. [ ]Ms. [ ]Miss [ ]Dr. [ ]Rev.

Address:_____
Street City State/Zip

Phone: Home: _____ Work: _____ Cell:_____

By what name do you prefer to be called?_____

How did you hear about our practice?_____

Names of other family members seen by us?_____

In the event of an emergency, who should be contacted?

Name: _____Relationship to Patient:_____

Phone #1: _____ ___Phone #2:_____

Are you a student? [ ]No [ ]Yes [ ]Full-time [ ]Part-time

Name of School:_____**Address**:_____

Name of person to be billed for this account: [ ]Self [ ]Spouse [ ]Parent [Other]

If other than yourself, please fill out below:

Name:_____ **Date of Birth**: / /

Address:_____
Street City State/Zip

Telephone Numbers: Home:_____Work:_____Ext._____

I understand that I am financially responsible for services rendered.

Signature of responsible person:_____ **Date: / /**

EMAIL ADDRESS:**_____**
For confirmations only

Please complete reverse side also.

PRIMARY - DENTAL INSURANCE INFORMATION

Name of Policy Holder:_____ **Date of Birth**: / /
Last First Middle Initial

Your relationship to policy holder: [ ]Self [ ]Spouse [ ]Parent [ ]Other

Address of Policy Holder: _____

Social Security Number of Policy Holder:_____

Group #_____ Effective Date of Policy:_____

Name of Insurance Company:_____ Toll Free Phone: _____

Address:_____
Street City State/Zip

Policy Holder's Employer

Name:_____

I authorize release of any information relating to my insurance claims. I understand that I am responsible for all costs of dental treatment including balances not covered by insurance.

_____
Signature of Patient or Parent/Guardian

I hereby authorize payment of the group health insurance benefits directly to Drs. Kalil and Kress.

_____
Signature of Policy Holder

_____

SECONDARY - DENTAL INSURANCE INFORMATION

Name of Policy Holder:_____ **Date of Birth**: / /
Last First

Your relationship to policy holder: [ ]Self [ ]Spouse [ ]Parent [ ]Other

Address of Policy Holder: _____

Social Security Number of Policy Holder:_____

Group #_____ Effective Date of Policy:_____

Name of Insurance Company:_____ Toll Free Phone: _____

Address:_____
Street City State/Zip

Policy Holder's Employer

Name:_____

I authorize release of any information relating to my insurance claims. I understand that I am responsible for all costs of dental treatment including balances not covered by insurance.

_____
Signature of Patient or Parent/Guardian

I hereby authorize payment of the group health insurance benefits directly to Drs. Kalil and Kress.

_____

Signature of Policy Holder