

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