

**Patient Information**

Title \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Email \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell \_\_\_\_\_

How would you like to be contacted? Phone \_\_\_\_\_ Email \_\_\_\_\_ Text \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc Sec \_\_\_\_\_  Male  Female

Marital Status  Single  Married  Divorced  Separated  Widowed

How did you hear about us? Please be specific \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Current Physician & Phone Number \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Responsible Party (if other than the patient)**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_ Cell \_\_\_\_\_

**Primary Insurance Information**

Subscriber Name \_\_\_\_\_ Soc Sec \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co \_\_\_\_\_

Employer Full Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Insurance Co Phone \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

**Secondary Insurance Information**

Subscriber Name \_\_\_\_\_ Soc Sec \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Co \_\_\_\_\_ Insurance Co Phone \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

- The information on this page and the medical history is correct to the best of my knowledge.
- I hereby authorize Dr. Stockburger, DDS, PC and/or such persons of his staff as he may select, to perform or assist in the performance of whatever dental treatment he deems appropriate following standards of care.
- I understand that *payment is expected when services are rendered.*
- I understand that a billing fee of *\$5.00 per month* will be added to any balance over 60 days. I accept responsibility for payment of all charges incurred as well as attorney's fee and any other related costs of collection should such action become necessary.
- I understand that I will be charged a *no-show fee of \$75.00* if I don't call to cancel an appointment within 48 hours of the scheduled appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible party (if patient is under 18) \_\_\_\_\_ Date \_\_\_\_\_