Patient Information

Name_____ Sex: ( ) Male ( ) Female

DOB _____ SSN_____DL#_____

Home Address_____

City_____ State_____ Zip_____

Billing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Would you like to be confirmed via text or email? (Y) (N)
Best number to send text's to: _____
Email: _____

Person to Contact in Case of Emergency

Name_____ Relationship_____ Phone_____

Medical Insurance

Insurance Company Name_____
Claims Address_____
Phone _____Group Number_____ID Number_____
Insured's Name_____Relation to Patient _____
Insured's DOB_____SSN_____Employer_____

Dental Insurance

Insurance Company Name_____
Claims Address_____
Phone _____Group Number_____ID Number_____
Insured's Name_____Relation to Patient _____
Insured's DOB_____SSN_____Employer_____

I understand that even though I have some insurance coverage, I am responsible for payment of services. I authorize release of information to my insurance company and referring dentist/physician. I hereby authorize my insurance company to release payment directly to James B. Phillips, MS, DDS, FICD, FAACS, PA. I have completed this form fully and certify that I am the patient and /or dully authorized agent of the patient authorized to furnish the information request. I hereby acknowledge that I have received a copy of these practices, notice of privacy practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature_____ Date_____