(Please Print)

PATIENT INFORMATION

Date _____

Social Security # _____

Pat. Name Last_____

First_____ MI___ Sex M F

Address Street_____

Apartment #_____ City_____

State_____ Zip_____

Birthdate _____

☐Married ☐Widowed ☐Single ☐Minor

☐Seperated ☐Divorced ☐Partnered

Employer_____

Occupation_____

☐College Student School_____

Spouse's (or Parent's) Name_____

_____

Birthdate_____

Social Security # _____

Address (if different)_____

_____

DENTAL INSURANCE

Subscriber's Name_____

Relationship to Patient_____

Insurance Company_____

Group #_____ ID #_____

Is patient covered by another insurance ☐yes ☐no

If yes, Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Company_____

Group #_____ ID #_____

Assignment & Release

I hereby authorize the office of Robert S. Gurmankin, DMD to affix my name to any and all claims or documents as related to any or all health insurance benefits due me or my dependents. I authorize the release of any information relating to my health care claims. I understand that I am responsible for all costs of dental treatment.
I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. This **"Signature On File"** will be valid from this date forth. A photocopy of this document may act as an original.

_____ _____
Todays Date Signature of Patient, Parent, Guardian or Insured

_____ _____
Relationship to patient Witnessed by

CONTACT INFORMATION

Home Phone _____ Work Phone_____ Cell Phone_____

E-mail_____ Best way to contact you ☐Home # ☐Work # ☐Cell # ☐E-mail ☐Text

Emergency Contact: Name _____

Relationship _____ Phone number_____

Whom may we thank for referring you?_____

For office use