PATIENT INFORMATION FORM FOR MERRILL DENTAL

Patient Name____ Date______________
Last First MI
Adress:____
Street City State Zip Code

Phone #'s Home___________________ Cell___________________ Work______________________
E-Mail Address____
Gender(M/F)___ Marital Status____________ Birth date______________ SS#__________________________
Please tell us how you selected our office or who we may thank for referring you?____

Spouse or Responsible Party Information

Name____
Last First MI
Adress:____
Street City State Zip Code
Phone #'s Home________________ Cell________________ Work_________________
E-Mail Address____
Gender(M/F)___ Marital Status____________ Birth date_______________________ SS#____________________________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment
Employer Name:____
Adress:____
Street City State Zip Code Phone #

Insurance Information

Primary Insurance
Name of Insured Person____
Last First MI
Adress:____
Street City State Zip Code Phone #

Insured's Birth Date________________ ID#_______________________ Group#________________________
Insurance Plan Name:____
Adress:____
Street City State Zip Code Phone #
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer's Name and Adress:____

Secondary Insurance
Name of Insured Person____
Last First MI
Adress:____
Street City State Zip Code Phone #

Insured's Birth Date________________ ID#_______________________ Group#________________________
Insurance Plan Name:____
Adress:____
Street City State Zip Code Phone #
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer's Name and Adress:____

Assignment of Benefits: I authorize payment of dental and medical benefits to the named provider for professional services rendered
Signed____ Date_____________________

Release of Information: I authorize the release of any dental and medical information necessary to process claims.
Signed____ Date_____________________