PATIENT INFORMATION FORM FOR MERRILL DENTAL

Patient Name_____ Date_____
Last First MI
Address:_____
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
Address:_____
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:_____
Address:_____
Street City State Zip Code Phone #

Insurance Information

Primary Insurance
Name of Insured Person_____
Last First MI
Address:_____
Street City State Zip Code Phone #

Insured's Birth Date_____ ID#_____ Group#_____
Insurance Plan Name:_____
Address:_____
Street City State Zip Code Phone #
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer's Name and
Address:_____

Secondary Insurance
Name of Insured Person_____
Last First MI
Address:_____
Street City State Zip Code Phone #

Insured's Birth Date_____ ID#_____ Group#_____
Insurance Plan Name:_____
Address:_____
Street City State Zip Code Phone #
Patient relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer's Name and Address:_____

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_____