

Frailman Prosthodontics

Patient Information

Patient Name _____ Birthdate _____ Home Phone () _____
Address _____ City _____ State _____ Zip _____

Sex M F Married Widowed Single Minor Separated Divorced Partnered

Email _____ Cell Phone () _____
Employer/School _____ Employer/School Phone () _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone () _____

Responsible Party Information

Name of Responsible Party _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Birthdate _____
Phone (Home) _____ Phone (Work) _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Address _____ City _____ State _____ Zip _____

Authorization And Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have any change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Frailman all
Name of Insurance Company

Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Frailman may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date