PATIENT INFORMATION:

Date

Patient Name

Social Security Number

Address

City State Zip

E-mail @

Sex Male ❑ Female ❑

Birthdate Age

Married ❑ Widowed ❑
Single ❑ Minor ❑
Separated ❑ Divorced ❑
Partnered ❑

Occupation

Patient Employer or School

Employer/School Address

Employer/School Phone ( )

Spouse's Name

Social Security Number

Birthdate

Spouse's Employer

Whom may we thank for referring you?

PHONE NUMBERS:

Home ( )

Work ( ) Ext

Cell Phone ( )

Spouse's Work ( )

Best time and place to reach you

DENTAL INSURANCE:

Who is responsible for this account?

Relationship to Patient

Insurance Co.

Group # Employer

Is patient covered by additional insurance? Yes ❑ No ❑

Subscriber's Name

Birthdate SS#

Relationship to patient

Insurance Co

Group # Employer

EMERGENCY CONTACT:

In case of emergency, contact (specify someone who does not live in your household.)

Name

Relationship

Home Phone ( )

Work Phone ( )

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Amine G. Khoury all 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.

Amine G. Khoury, D.D.S. 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 or Legal Guardian

Please print name of Patient, Parent or Legal Guardian

Date Relationship to Patient