

Health and Insurance Record

Sex: Male Female

Date: _____

Patient Name: _____ Birth Date: _____
Last First Middle

Residence: _____
Street City State Zip

Social Security #: _____ Cell Phone #: _____ Home Phone #: _____

Occupation: _____ Marital Status: Single Married Widowed Divorced

Name and address of employer: _____
Business/Employer Phone #: (____) _____ DENTAL Insurance - your employer: Yes No
MEDICAL Insurance - your employer: Yes No

Name of Spouse: _____ Social Security #: _____ Birth Date: _____

Spouse's Employer Name and Address: _____
Business/Employer Phone #: (____) _____ DENTAL Insurance - spouse employer Yes No
MEDICAL Insurance - spouse employer Yes No

E-Mail Address: _____

If Patient is a Minor

Father's Name: _____ Birth Date: _____ Mother's Name: _____ Birth Date: _____

Father's Social Security #: _____ Mother's Social Security #: _____

Name of Father's Employer: _____ Name of Mother's Employer: _____

Parent's address:(if different from child's) _____

Business/Employer Phone #: (____) _____ Business/Employer Phone #: _____

DENTAL Insurance - Father's Employer Yes No **DENTAL** Insurance - Mother's Employer Yes No

MEDICAL Insurance - Father's Employer Yes No **MEDICAL** Insurance - Mother's Employer Yes No

If patient a full time student: Name of School: _____ Graduation Date: _____

Name and address of closest relative: _____ Phone #: _____

Name of person responsible for financial obligation: _____

Whom may we thank for your referral to this office? _____

For and in consideration of services rendered and/or to be rendered, I, the undersigned, hereby assign to The Stenvall Group, D.M.D., P.A., any and all Dental/Medical Benefits which I may have under any policy of insurance. I will also be responsible for any balance owing after application of payment by any dental/ medical benefit payments. In the event the account should become delinquent for a period of thirty (30) days, I hereby acknowledge that an interest charge of 1.5% per month, 18% per year will be added to the unpaid balance. I will be responsible for any collection agency, court costs and/or attorney fees, (33% of outstanding balance), if incurred.

All financial arrangements will be predicated on the outcome of a credit report.

X _____
Signature of insured or authorized person

PLEASE TURN FORM OVER - CONTINUED ON OTHER SIDE