

PATIENT INFORMATION FORM

NAME (Last, First, MI) _____ PREFERRED NAME _____

HOME ADDRESS _____
(street) (city) (state) (zip)

HOME PHONE _____ WORK PHONE _____ CELL NO. _____

SS# _____ - _____ - _____ DATE OF BIRTH ____/____/____ SEX: M / F STATUS: S/ M/ D/ W

EMPLOYER NAME _____

NAME OF SPOUSE _____

EMERGENCY CONTACT & PHONE _____

RELATIONSHIP TO PATIENT _____

PLEASE CHECK WHICHEVER APPLY:

- PRIMARY DENTAL INSURANCE ONLY; SUBSCRIBER NAME _____
- PRIMARY DENTAL INSURANCE & SECONDARY DENTAL INSURANCE
- NO DENTAL INSURANCE AT THIS TIME

James G. Fritsche D.D.S., S.C.

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THE ABOVE INFORMATION IS GIVEN FOR THE PURPOSE OF OBTAINING CREDIT, AND I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, AS OF THE DATE OF THIS APPLICATION. I GIVE MY PERSONAL GUARRANTEE FOR ALL CHARGES INCURED.

SIGNATURE _____ DATE _____

RESPONSIBLE (if under 18 years of age)
PARTY

(Name) (Address) (SS#)