Da Vinci Dental Group

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. Fraiman 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. Fraiman 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**