Alyce O'Brien & Jack Batjer, D.D.S., P.L.L.C..

Patient Information

ABOUT YOU

Today's Date:_____

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Email Address: _____ Driver's License #: _____

Home Phone #: ( ) _____ Pager/Car #: ( ) _____ Work Phone #: ( ) _____ Ext: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Work Phone #: ( ) _____ Home Phone #: ( ) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: ( ) _____ Social Security #: _____

Employer: _____ Work Phone #: ( ) _____ Ext: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: ( ) _____ Ext: _____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

My method of payment will be (circle one – cash, check, Visa, Master Card, Amex). Card #_____ Exp. Date _____

Signature _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE