Patient Information

Last Name________________________________First_______________________Middle__________
DOB___/___/___ SS#_____________________ Minor__ Single__ Married__ Divorced__ Widowed__
Street Address_____________________________ Employer Name___________________________
City/State/Zip______________________________ Street Address____________________________
Home Phone_______________________________ City/State/Zip_____________________________
Cell Phone________________________________ Work Phone______________________________
E-mail____

Responsible Person (if other than patient)

Relationship to patient_______________________
Last Name_________________________________ First_____________________Middle___________
DOB____/____/____ SS#_____________________ Single___ Married___ Divorced___ Widowed___
Street Address_____________________________ Employer Name___________________________
City/State/Zip______________________________ Street Address____________________________
Home Phone_______________________________ City/State/Zip_____________________________
Cell Phone________________________________ Work Phone______________________________
E-mail____

Insurance Coverage

Primary Dental Insurance

Insurance Co. Name_________________________
Address___________________________________
Phone________________ Grp#______________
Insured's Name_________ ___________________
Insured's DOB__/___/___ SS#______________
Relationship to Patient______________________
Insured's Employer_________________________

Secondary Dental Insurance

Insurance Co. Name_________________________
Address___________________________________
Phone__________________ Grp#_____________
Insured's Name__________________ ___________
Insured's DOB__/___/___ SS#________________
Relationship to Patient________________________
Insured's Employer_______________ ___________

General Information

Person to contact for emergency________________________________ Phone___________________
Address_____________________________ City/State/Zip____________________________________
Has any member of your family been here before? Name:______________________________________
Whom may we thank for referring you to this office? Name:___________________________________
Closest Relative not living with you_______________________________ Phone___________________
Address_____________________________ City/State/Zip____________________________________

Signature on File

I,__________________________________, hereby authorize__________________________________
(Name of Insured) (Dental Insurance Co.)
to pay and hereby assign directly to **Michael T. Woolf, D.D.S.** all benefits, if any, otherwise payable to me for services performed in this office. I understand I am financially responsible for all charges incurred. Authorization is hereby given to release all information necessary to the payment of said benefits.

____ _____________
Authorized Signature of Covered Person/Employee Date

____ _____________
Signature - Patient or Parent of Minor Date