

GLENN R. BURNS, D.D.S., F.A.G.D. AND JENNIFER J. LAPE, D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

Patient's name: _____		Date of birth: _____	Social Security #: _____	
Last	First	M.I.		
Sex: __ Male __ Female		Status: __ Married __ Single __ Divorced __ Widowed __ Separated		Spouses Name: _____
Do you go by another name? _____		If married, do you give permission for us to speak to your spouse? _____		
Home address: _____				
Street Address		City	State	Zip
Home phone number: _____		Work number: _____	Ext. _____	Cell phone number: _____
What number is best to reach you at? _____		Email address: _____		
Patient's employer: _____		Occupation: _____		
Employer's address: _____		City: _____	State: _____	Zip: _____
Name of person to contact in case of an emergency: _____		Phone number: _____		
Whom may we thank for referring you to our practice? _____				

INSURANCE INFORMATION

Name of insured: _____		Date of birth: _____	Social Security Number: _____	
Relationship to patient: _____		Insured's address: _____		
Street Address		City	State	Zip
Name of employer: _____		Work phone number: _____		
Name of insurance company: _____		Do you have an insurance card? _____		

RESPONSIBLE PARTY

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize this office to bill my insurance. I understand that I am responsible for this bill should my insurance not pay. If I am delinquent in paying my account I understand that I will pay interest on the overdue balance at a rate of one and a half percent (1.5%) per month. I understand that any fees involved in collecting this balance are my responsibility. I also understand that if I fail to honor my payment arrangements and/or default in payment that I may be turned over to a collection agency at the discretion of this office.				
Patient/Guardian/Responsible Party		Today's Date	Date of Birth	Social Security Number
Street Address		City	State	Zip
				Phone Number