Patient Information

Name:_____ ☐ ☐ ☐
Last First MI Mr., Mrs, Ms.

Home Address:_____
Apt/Condo #

_____
City State Zip

SS#_____ Student School:_____

Home #: _____ Work #: _____

Cellular _____ Email _____

Employer: _____

○ ○ ○ ○
Single Married Sex: M F Birthdate:____ ____ ____ Age:____

Spouse Name: _____

Who May We Thank for Referring You:_____

Employer's Address: _____

How Long There? _____ Occupation:_____

Best Times to Reach You:_____

Spouse Information

Name:_____

Employer:_____

Work #: _____

SS#:_____ Birthdate:_____

Person Responsible for Account

Name: _____

Billing Address:_____

_____
City State Zip

Relation:_____ SS#:_____

Employer:_____

Work #:_____Home #:_____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name:_____

Ins. Co. Address: _____

_____

Ins. Co. Phone #:_____

Insured's Name:_____

Relation:_____ Group #:_____

Birthday: _____SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name:_____

Address:_____

_____

Ins. Co. Phone #: _____

Insured's Name:_____

Relation:_____ Group #:_____

Birthday:_____ SS#:_____

Insured's Employer: _____

Medical Insurance Carrier

_____

Physician's Name: _____

In the event of an emergency, is there someone that we should contact?

Name:_____
Relationship:_____
Wk#:_____ HM#:_____

I hereby authorize payment directly to Dr. Khoury of the group insurance benefits otherwise payable to me.

Signed :_____

If you have insurance, we will file your forms promptly, and request that you pay your portion when the services are rendered. You are also responsible for any balance not covered by your insurance plan. Please bring your insurance card and forms with you. If you do not have insurance we request payment in full at the time of services unless other arrangements have been made. **I have read and understand the above financial information.**

Patient or Responsible Party Signature:_____ **Date:**_____