Patient Information Sheet

Patient Information

Name _____ T.D.L._____
Last First Middle
Address_____City_____St_____Zip_____
Phones
Home_____ Work_____ Cell _____
Social
Security #_____ Birthdate_____ Sex_____

E-mail_____

Employer_____ Address_____

Spouse Information

Name_____ Cell phone_____
Social
Security #_____ Birthdate_____ Work Phone_____

Employer_____ Address_____

Emergency Contacts

(1)Name_____ Phone_____

Address_____ Relationship to Patient_____

(2)Name_____ Phone_____

Address_____ Relationship to Patient_____

Insurance Information

Insurance Company_____ Phone #_____

Address_____Group #_____

Name of Subscriber_____ SS#_____

Relationship to Patient_____ Birthdate_____

Responsible Party for Account _____Self _____Spouse

Complete only if Responsible Party is someone other than yourself or your spouse
Name_____ Relationship to Patient_____
Social
Security #_____ Birthdate_____

Address_____ Phone_____

Employer_____ Work Phone_____

I directly assign all medical and/or surgical benefits to Dr. Sam Seale, DDS, MS. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign Here:_____ Date:_____