BRAZOS VALLEY PERIODONTICS
AND IMPLANT CENTER

Patient Information

Name ______________________________ T.D.L ____________
Last/First/Middle

Address ____________________ City ____________ St. ________ Zip ________

Phone Numbers

Home ______________ Work ______________ Cell ______________

Social Security ______________ Birthdate ______________ Sex ____________

Employer ____________________ Address ______________________

Emergency Contacts

Name ______________________________ Phone # ______________

Address ____________________________ Relationship ______________

Name ______________________________ Phone # ______________

Address ____________________________ Relationship ______________

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 ____________ Phone # ____________

Address ____

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.

______________________________ ______________

Patient Signature **Date**