PATIENT INFORMATION: PLEASE PRINT

How where you referred to our office? ____

Patients Full Name: ____

Date of Birth: _______________ Social Security #_______________ Sex: (M) (F) (NB)

Street Address: ____

City, State, Zip: _________________________ Email: _________________________

Home Phone #_______________ Cell #_______________

Marital Status: (Single) (Married) (Other): Spouses Name: _________________________

Are You over 18? (Yes) (No) If no, Please provide parent or legal guardians name and Social Security

Parent/Legal Guardians Name: _________________________ Social Security: _______________

Address: _______________________________________ Phone # _______________

City, State, Zip: ____

Emergency Contact: _________________________ Phone # _______________

Relationship: _________________________

EMPLOYER/SCHOOL

Name of Employer/ School: ____

(Full Time) (Part Time) (Retired) (Student)

City, State: _______________________________________ Phone # _______________

INSURANCE

Note: we will need a copy of your driver's license and insurance card

Primary Insurance: _________________________ Policy # _______________

If different from above; please complete

Policyholders Name: _________________________ Date of Birth: _______________

Social Security# _________________________ Employer: _________________________

PAYMENT DUE AT TIME OF SERVICE. **How will you be paying? (Cash) (Check) (Credit) (Debit) (Care Credit)**

I hereby authorize any insurance benefits to be paid directly to the office of Aaron Memon DMD, PA and or treating dentist and recognize my responsibility for all non-covered services as treatment plans are an estimate only. I also authorize the physician to release any information to process the insurance claim. I understand unpaid claims are my responsibility. A parent or guardian who will be responsible for payment of the bill at the time of service must accompany the child. We cannot be bound by divorce or other family relationship contracts.

Signature: _______________________________________ Date: _______________