PATIENT INFORMATION

Name_____ Single ☐ Married ☐ Divorced ☐
Last First Middle

Address_____
Apt # Street City State Zip

Age_____ Birthdate ___/___/_____ Sex: M ☐ F ☐ Soc. Sec. #_____
Month Day Year

Phone (H)_____ (C)_____ (FAX)_____ EMAIL_____

Patient Employed By_____ Occupation_____

Business Address_____ Phone_____

Whom May We Thank For Referring You?_____

Spouse (or Parent) Name _____ Phone_____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____ Phone (H)_____ (C)_____

Address_____
Apt # Street City State Zip

INSURANCE INFORMATION

Person Responsible for Account_____ Relation_____

Address_____

Phone (H)_____ (W)_____ Soc.Sec.#_____ Birthdate ___/___/____

Insurance CO_____ Contract #_____ Subscriber #_____

Group #_____ Names of Dependents on Plan_____

AUTHORIZATION

1. THE UNDERSIGNED CERTIFY THAT I HAVE INSURANCE COVERAGE WITH _____ AND AUTHORIZE PAYMENT DIRECTLY TO dR. ASHISH RASTOGI. ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL COSTS OF TREATMENT WHETHER OR NOT PAID BY THE INSURANCE COMPANY. I HEREBY AUTHORIZE THE DOCTOR TO ADMINISTER SUCH MEDICATIONS, PERFORM SUCH DIAGNOSTIC TESTS AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. THE INFORMATION ON THIS FORM AND MEDICAL HISTORY FORMS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND I GRAND THE RELEASE OF INFORMATION NECESSARY TO OBTAIN THIRD PARTY PAYMENTS.

X_____ _____ _____ _____
Signature Relationship Date State Drivers License#