WELCOME TO OUR PRACTICE

GREGORY G. ERRAMOUSPE D.D.S.

PATIENT INFORMATION: (confidential)

LAST NAME	FIRST NAME	MI	PREFERRED NAME
SEX M F	MARITAL STATUS S M D W	DATE OF BIRTH ___/___/______	SOC. SEC. #
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE#	CELL PHONE#	EMPLOYER
EMAIL ADDRESS			

RESPONSIBLE PARTY:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOC.SEC.#
ADDRESS	CITY	STATE	ZIP	
HOME PHONE	WORK PHONE#	CELL PHONE#	EMPLOYER	
EMPLOYER ADDRESS	CITY	STATE	ZIP	

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP

INSURANCE INFORMATION:

PRIMARY INSURANCE CO	NAME OF EMPLOYER	POLICY HOLDER NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER ID#	GROUP#	INSURANCE PHONE#	
INSURANCE ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE:

SECONDARY INSURANCE CO	NAME OF EMPLOYER	POLICY HOLDER NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER ID#	GROUP#	INSURANCE PHONE#	
INSURANCE ADDRESS	CITY	STATE	ZIP

I authorize and request my insurance company to pay the Dentist directly. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance claims.

Signed ____ *Date*________________