Red Door Dental

PATIENT INFORMATION

Home Phone (_____)_____ Cell Phone (_____)_____ Date _____

Name _____ E-mail_____
Last Name First Name M.I.

Address _____ SS#_____

City _____ State _____ Zip _____

Sex O M O F Age_____ Birth date_____ O Married O Widowed O Single O Divorced

Patient Employer/School_____

Emergency contact_____ Phone (_____)_____

INSURANCE

Person Responsible for Account _____
Last Name First Name M.I.

Relation to Patient_____ Birth date_____ SS#_____

Address (if different from patient's)_____ Phone (_____)_____

City_____ State_____ Zip_____

Person Responsible Employed by_____

Insurance Company_____

Group #_____ Subscriber #_____

Is patient covered by additional insurance? O No O Yes Name of Ins. Co. _____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of Insurance Company) and assign directly to Dr. Larsen all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies).

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient