ASSOCIATES IN PERIODONTICS
Brian Shuman, DMD
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PATIENT INFORMATION (CONFIDENTIAL)

ID#____________________

Prefix: MR. MRS. MS. DR _____

NAME ____________________ SSN# ________ DATE ________

FIRST MI LAST

ADDRESS ________ CITY ________ STATE _____ ZIP _____

HOME PHONE ________ WORK PHONE ________ CELL PHONE ________

BIRTHDATE ________ EMPLOYER ________ EMAIL ________
(e-mail never shared)

IF STUDENT, F.T./P.T., NAME OF SCHOOL ________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY, ________ PHONE ________

WHOM MAY WE THANK FOR REFERRING YOU? ________________

RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE, PLEASE FILL OUT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT________ RELATIONSHIP TO PATIENT ________

ADDRESS ________ HOME PHONE ________

BIRTHDATE ________ SS# ________

EMPLOYER ________ WORK PHONE ________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PRIMARY DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME ________ RELATIONSHIP TO PATIENT ________

BIRTHDATE________ SS3 ________

NAME OF EMPLOYER ________ UNION OR LOCAL ________ WORK PHONE ________

EMPLOYER ADDRESS ________ CITY ________ STATE _____ ZIP _____

INSURANCE CO. ________ TEL# ________ GRP# ________ POLICY# ________

INSURANCE CO. ADDRESS ________ CITY ________ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE BELOW

SECONDARY DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME ________ RELATIONSHIP TO PATIENT ________

BIRTHDATE ________ SS# ________

NAME OF EMPLOYEER________ UNION OR LOCAL# ________ WORK PHONE ________

EMPLOYEER ADDRESS________ CITY ________ STATE _____ ZIP _____

INSURANCE CO. ________ TEL# ________ GRP# ________ POLICY# ________

INSURANCE CO. ADDRESS ________ CITY ________ STATE _____ ZIP _____

MEDICAL INSURANCE INFORMATION

SUBSCRIBER NAME ________ RELATIONSHIP TO PATIENT ________

INSURANCE CO. ________ TEL# ________ GRP# ________ POLICY# ________

INSURANCE CO. ADDRESS ________ CITY ________ STATE _____ ZIP _____

Authorization to release information to the insurance company

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SIGNATURE OF PATIENT OR PARENT/GUARDIAN