Patient Information Form

Patient's Name_____Date_____

Address_____City_____State_____Zip_____

Phone (cell)_____(home)_____(work)_____

Email_____Birth Date_____

Check Appropriate Box □ Minor □ Single □ Married □ Divorced/Separated □ Widowed

Patient's Employer_____Occupation_____Student Status FT PT

Emergency Contact_____Phone_____

Who may we thank for referring you to our office?_____

Responsible Party (if someone other than the patient)

First Name_____Last Name_____

Address_____City_____State_____Zip_____

Phone (cell)_____(home)_____(work)_____

Birth Date_____Relationship to patient_____Email_____

Employer_____

□ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Holder □ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured_____Relationship to Patient ○ Self ○ Spouse ○ Child ○Other

Insured SS#/Employee ID #_____Insured Birth Date_____

Employer_____Employer Address_____

Insurance Company_____Insurance Address_____

Secondary Insurance Information

Name of Insured_____Relationship to Patient ○ Self ○ Spouse ○ Child ○Other

Insured SS#/Employee ID #_____Insured Birth Date_____

Employer_____Employer Address_____

Insurance Company_____Insurance Address_____

Authorization and Release

Our office will submit all insurance claims for you, however, we are non-participating providers. Your payment/insurance co-payment is due at the time service is rendered. We accept cash, check, VISA and Mastercard.

I authorize Kristin F. Nickodemus, DDS, PLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company pay directly to Kristin F. Nickodemus, DDS, PLC insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ Date_____

Signature of patient (or parent if minor)

We request 48 hour notice if you are unable to keep your appointment. Appointments broken without adequate notice will be accessed a charge.

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