DESERT RIDGE IMPLANT & ORAL SURGERY

PATIENT INFORMATION

Date_____ Soc Sec#_____ Birthdate _____ Age _____
Name _____ ˆ Male ˆ Female
Hm. # _____ Wk. # _____ Cell # _____
Address _____ Apt. # _____
City _____ State _____ Zip _____
ˆ Minor ˆ Single ˆ Married ˆ Divorced ˆ Widowed ˆ Separated
Are you a full time student? Yes ____ No ____ College/School _____
Employer _____ Business # _____
Address _____ Occupation _____
In case of emergency, whom should we contact? _____
Phone # _____

Referred by: _____
Dentist's Name: _____

PRIMARY INSURANCE

Person Carrying Insurance _____
Birthdate _____ Soc. Sec. # _____ Relationship to Patient_____
Address _____ Apt # _____ Hm. # _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Occupation _____
Business Address _____ Business # _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE(IF APPLICABLE)

We do not bill secondary insurance unless we are participating network providers
Insured Name _____ Relationship to Patient _____
Birthdate _____ Soc. Sec. # _____
Address _____ Apt. # _____ Hm. # _____
City _____ State _____ Zip _____
Insured Employed By _____ Business # _____
Insurance Company _____
Insurance Company Address _____
Subscriber I. D. # _____ Group # _____

ASSIGNMENT & RELEASE

I hereby authorize payment to **Desert Ridge Implant & Oral Surgery** for all Insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance, and for all services rendered on my behalf or my dependent. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____