George A Stone DMD PA

FAMILY DENTISTRY

1115 EGLIN PKWY • SHALIMAR FL 32[illegible] • 850-651-1125

1 ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ___ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____)_____

Work Phone #: (_____)_____ #Ext: _____

Cell Phone #: (_____)_____

E-mail Address: _____

Referred By: _____

EMPLOYER: _____ How Long?_____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____)_____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____)_____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____)_____

(_____) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
INITIALS

4 IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (_____)_____

Work Phone #: (_____)_____

Cell Phone #: (_____)_____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____)_____

PLEASE CONTINUE ON BACK