PATIENT INFORMATION

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name *(First, M.I., Last):*

Date of Birth: Age:

Sex: Male / Female Marital Status: S M W D

Address: (Street) (City) (State) (ZIP)

Phone #: Social Security #: Driver's License #:

Work #: Employer:

General Dentist: Office Name: Phone:

Orthodontist: Office Name: Phone:

Medical Physician: Phone:

E-mail:

ALTERNATIVE CONTACT

Name: Relationship to Patient:

Address:

Phone #: Social Security #: Driver's License #:

Employer: Work #:

Friend or Relative Not Living with You:

INSURANCE INFORMATION

DENTAL FIRST

Insurance Co.:	Phone #:
Insurance Address:	
Group #:	Certificate or ID #:
Insured's Name:	Relationship to Patient: Self / Spouse / Dependent
Insured's Employer:	Phone #:
Employer's Address:	
Insured's Social Security #:	Date of Birth: Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE INFORMATION

Medicare #:	Medicaid #:
Insurance Co.:	Phone #:
Insurance Address:	
Group #:	Certificate or ID #:
Insured's Name:	Relationship to Patient: Self / Spouse / Dependent
Insured's Employer:	Phone #:
Employer's Address:	
Insured's Social Security #:	Date of Birth: Sex: Male / Female

GRIEVANCE POLICY
Patients should notify the medical director in writing of any concerts or complaints or disagreement about care decision between the patient and care provider.

I hereby assign, transfer, and set over to Alexander V Antipov, DDS, Inc., all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoking said authorization give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____