Patient Information

Last Name_____First_____Middle_____
DOB___/___/___ SS#_____ Minor__ Single__ Married__ Divorced__ Widowed__
Street Address_____ Employer Name_____
City/State/Zip_____ Street Address_____
Home Phone_____ City/State/Zip_____
Cell Phone_____ Work Phone_____
E-mail_____

Responsible Person (if other than patient)

Relationship to patient_____
Last Name_____ First_____Middle_____
DOB____/____/____ SS#_____ Single___ Married___ Divorced___ Widowed___
Street Address_____ Employer Name_____
City/State/Zip_____ Street Address_____
Home Phone_____ City/State/Zip_____
Cell Phone_____ Work Phone_____
E-mail_____

Insurance Coverage

Primary Dental Insurance

Insurance Co. Name_____
Ins. Co. Address_____
Phone_____ Grp#_____
Subscriber's Name_____
Subscriber's DOB___/___/___SS or ID#_____
Relationship to Patient_____
Subscriber's Employer_____

Secondary Dental Insurance

Insurance Co. Name_____
Ins. Co. Address_____
Phone_____ Grp#_____
Subscriber's Name_____
Subscriber's DOB___/___/___ SS or ID_____
Relationship to Patient_____
Subscriber's Employer_____

General Information

Person to contact for emergency_____ Phone_____
Address_____ City/State/Zip_____
Has any member of your family been here before? Name:_____
Whom may we thank for referring you to this office? Name:_____
Closest Relative not living with you_____ Phone_____
Address_____ City/State/Zip_____

Signature on File

I,_____, hereby authorize_____
(Name of Insured) **(Dental Insurance Co.)**

to pay and hereby assign directly to **Alexander S. Nahigian, D.D.S.** all benefits, if any, otherwise payable to me for services performed in this office. I understand I am financially responsible for all charges incurred. Authorization is hereby given to release all information necessary to the payment of said benefits.

_____ _____
Authorized Signature of Covered Person/Employee Date

_____ _____
Signature - Patient or Parent if Minor Date