



Patient's Name _____ Male _____ Female _____
Last First M.I.

Patient's SS# _____ Birthdate _____ Marital Status _____

Mailing Address _____
City, State, Zip

Home Phone (____) _____ Work Phone (____) _____ Ext. _____

Employer _____ Cell Phone (____) _____

Spouse's Name _____ Spouse's SS# _____

Spouse's Employer _____ Spouse's Work Phone (____) _____

Spouse's Birthdate _____ Ext. _____

Financially Responsible Person _____
(If different from patient)

Address _____
City, State, Zip

Home Phone (____) _____ Work Phone (____) _____ Ext. _____

Relationship to Patient _____

Primary Dental Insurance Co. _____

Insurance Address _____

Ins. Co. Phone (____) _____ City, _____ State, _____ Zip _____

Subscriber's Employer _____

Group/Plan/Policy# _____ Subscriber's Name _____

Subscriber's SS# _____ Subscriber's Birthdate _____

Secondary Dental Insurance Co. _____

Insurance Address _____

Ins. Co. Phone (____) _____ City, _____ State, _____ Zip _____

Subscriber's Employer _____

Group/Plan/Policy# _____ Subscriber's Name _____

Subscriber's SS# _____ Subscriber's Birthdate _____

Person to contact in case of Emergency _____

Address _____
City, State, Zip

Home Phone (____) _____ Work Phone (____) _____ Ext. _____

Relationship to Patient _____

How did you hear about LEESBURG DENTAL? _____

AUTHORIZATION AND INSURANCE ASSIGNMENT

I authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to this office. I understand and agree that, regardless of my insurance status, I am responsible for my account and any collection and/or attorney fees that are incurred if the balance is not paid in a timely fashion.

Signature _____ Date _____