Beachwood

Patient Information

Date:______________

PATIENT NAME:____

Spouse's Name:_______________________________ Children's Name:__________________________

Address:_____________________________City:_____________________ State:____ Zip:____________

Home Phone:_____________________Cell:_______________________ Email:______________________

Patient Employer:____ Phone #:________________________

Address:____________________________ City:____________________ State:_____ Zip:____________

Present Position: ____________________________________ How Long: _________________________

Spouse Employer: _______________________________________ Phone #:________________________

Address:___________________________ City:______________________ State:_____ Zip:___________

Present Position:____________________________________ How Long:___________________________

Person Responsible for account:____

Patient Social Security Number:______________________________ Date of Birth:_______________

Spouse Social Security Number:______________________________ Date of Birth:_______________

Primary Insurance :_________________________________ Group ID #:__________________________

Subscriber relation to patient: Self:__ Guarantor:__ Other:____________________________

Subscriber Member ID Number:______________________ Subscriber S.S#:_______________________

Secondary Insurance: ______________________________ Group ID#:____________________________

Subscriber relation to patient: Self:__ Guarantor:__ Other:____________________________

Subscriber Member ID Number:______________________ Subscriber S.S.#:______________________

Emergency Contact:________________________________ Phone:_______________________________

Medical Doctor Name: _____________________________ Phone:________________________________

Whom shall we thank for referring you? ____

ON ANY OUTSTANDING BALANCE CARRIED OVER 90 DAYS, THERE WILL BE A SERVICE CHARGE OF 1.5% PER MONTH.

________________________________ ____

Driver's License Exp. Date Patient's Signature (Guardian if minor)

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employees such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered here at Beachwood.

____________________________________ ___________________________ ______

Signature of responsible party Relationship Date