PETER A. JURIANSZ, D.M.D.
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WELCOME

Patient Name: _____
LAST FIRST MI

Name You Prefer To Be Called: _____

☐ Male ☐ Female

Date of Birth: ___/___/_____ Age: _____

Social Security Number: _____

Mailing Address: _____

_____
CITY STATE ZIP

Prefered to be reached by:

Home Phone Number: _____ ☐

Cell Phone Number: _____ ☐

Work Phone Number: _____ ☐

Email Address: _____

Occupation: _____

Employer: _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do You Have Children? ☐ Yes ☐ No How Many? _____

Referred by: _____

EMERGENCY CONTACT INFORMATION

Who should we contact in an event of an emergency?

Name: _____

Relation: _____

Phone Number: _____

Who is your Medical Doctor: _____

M.D.'s Phone #: _____

INSURANCE INFORMATION

Do you have dental insurance?

☐ Yes ☐ No (please skip to the next section)

PRIMARY DENTAL INSURANCE

Insurance Company: _____

Insurance's address: _____

_____

Phone Number: _____

Subscriber ID: _____

Group Number: _____

Employer or Group Name: _____

Are you the subscriber to the plan? ☐ Yes ☐ No

If you answered 'No', please fill in:

Subscriber's Name: _____

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

SECONDARY DENTAL INSURANCE

Insurance Company: _____

Insurance's address: _____

_____

Phone Number: _____

Subscriber ID: _____

Group Number: _____

Employer or Group Name: _____

Subscriber's Name: _____

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

ACCOUNT INFORMATION

Person ultimately responsible for the patient's account:

☐ Patient ☐ Other/Guardian

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am soley resposible for any balance not paid by my insurance company.

_____
SIGNATURE OF PATIENT/GUARDIAN DATE

If Other/Guardian is checked, please fill out the information for that person:

Name: _____ Relation: _____

Phone Number: _____

Address: _____