MICHAEL K. SHINNERS, D.D.S.

Patient Information

Name: ____
Address: ____
____
City Zip

Employed by: _______________________________________

Phone Number: (_____)_______________________________

Best way to reach you: ☐ Cell ☐ Email ☐ Text

Spouse's Name: _____________________________________

In case of emergency: _______________________________

Phone Number: ______________________________________

Email Address: ______________________________
Date of Birth: _____/_____/______ Age: _________
Cell Number: (_______)________________________

Sex: ☐ Male ☐ Female

Marital Status:
☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Cellphone Number: (______)________________

Who may we thank for referring you to our office? ____

Insurance Information

If you have orthodontic insurance, please provide the following information so that we can verify your benefits.

Primary Dental Insurance: ______________________	Insurance ID# OR Social Security #: ______________________
Name of Insured: ______________________	Date of Birth: ______________________
Secondary Dental Insurance: ______________________	Insurance ID# OR Social Security #: ______________________
Name of Insured: ______________________	Date of Birth: ______________________

Responsible Party Information

I, the undersigned certify that I (or my dependents) have insurance coverage with ______________________ and assign directly to Dr. Michael K. Shinners, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ______________________
Responsible Party Signature Relationship Date

____
Phone

____
Address if different from Patient's