Patient Information Form:

Patient Name:_____ Birthdate: _____ SS #:_____

Address: _____ Cell Number: _____ Phone # _____

City:_____ State:_____ Zip Code: _____

Patient Employed by: _____ Occupation: _____

Business Address:_____ Business Phone: _____

Emergency Contact: _____ Phone: _____ Referred By:_____

PRIMARY INSURANCE

Person Responsible: _____ Birthdate: _____ SS #_____

Responsible Party's Employer:_____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company:_____ Group # _____

Insurance ID #: _____

SECONDARY INSURANCE

Subscriber Name: _____ Birthdate: _____ SS # _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ Group # _____

Insurance ID # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependents) have insurance coverage with _____
And assign directly to Dr. Michael K. Shinners, DDS,SC 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: _____