



JOHN M. OTRHALEK, D.D.S.

Family and Cosmetic Dentistry

### Patient Information

DATE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CIRCLE APPROPRIATE:    MINOR            SINGLE            MARRIED            DIVORCED            WIDOWED            SEPARATED

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ OTHER PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENTS NAME \_\_\_\_\_ PATIENT SOCIAL SECURITY # \_\_\_\_\_

IF PATIENT IS A STUDENT NAME OF SCHOOL/COLLEGE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY, OTHER THAN PARENT OR SPOUSE \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

#### ACCOUNT INFORMATION - RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE?    Yes    No    SOCIAL SECURITY # \_\_\_\_\_

#### INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?    Y    N    IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

#### APPOINTMENT INFORMATION

BEST TIME FOR AN APPOINTMENT    M    T    W    TH    F    S    AM    PM    FLEXIBLE

BEST PLACE TO CALL:    WORK \_\_\_\_\_ HOME \_\_\_\_\_ E-MAIL \_\_\_\_\_

I, \_\_\_\_\_, HEREBY IRREVOCABLY ASSIGN AND TRANSFER PAYMENT OF ANY AND ALL DENTAL BENEFITS TO WHICH I MAY BE ENTITLED FOR SERVICES PROVIDED BY JOHN M. OTRHALEK, D.D.S., PURSUANT TO CONTRACT OF DENTAL INSURANCE, GROUP DENTAL INSURANCE OR ANY OTHER TYPE OR FORM OF INSURANCE WHATSOEVER, AND AUTHORIZE PAYMENT OF SAID BENEFITS TO THE AFOREMENTIONED DENTIST. THIS ASSIGNMENT SHALL BE BINDING UPON MY HEIRS, EXECUTORS AND ADMINISTRATORS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE REFLECTING INSURANCE DEDUCTIBLES, CO-PAYS AND NON COVERED SERVICES. I AM ALSO FINANCIALLY RESPONSIBLE FOR ANY BALANCE THAT RESULTS FROM MY EXCEEDING THE MAXIMUM COVERAGE AS ESTABLISHED BY MY INSURANCE COMPANY.

DATE

PATIENT'S AUTHORIZED PERSONS SIGNATURE