LAUREN STANDEFER DDS

Date: _____

Patient Information

Patient Name: _____
(Last) (First) (Middle Initial)

Sex: M/F Date of Birth: _____ SSN#: _____ Marital Status: _____

Home Telephone: _____ Cell Phone: _____ Work: _____

Home Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Patient's Employer: _____ *Email Address*: _____

Emergency Contact Name: _____ Phone#: _____

Spouse's Name: _____ Phone #: _____

Name of nearest relative/friend not living with you: _____ Phone #: _____

How did you hear about our office? _____

Billing Information

Person Responsible for Bill: _____
(Last) (First) (Middle Initial)

Responsible Party's Home Telephone: _____ Cell: _____

SSN#: _____ Date of Birth: _____

Responsible Party's Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Responsible Party's Employer: _____ Business Telephone: _____

Insurance Information

As a courtesy, we will accept payment of benefits directly from your insurance company . No refunds are issued until your insurance company has settled claim(s), and our office has received full payment of benefits. Please fill out accurately and completely. The part of our fee that is not covered by insurance is due at the time of treatment.

Is insured a current patient? Y/N

Name of Insured: _____
(Last) (First) (Middle Initial)

Employer: _____ SSN#: _____ Date of Birth: _____

Name of Insurance Company: _____

Group number: _____ Telephone Number of Insurance Company: _____

_____ *Initials* ***CANCELLATION POLICY***: *As a courtesy to other patients, all cancellations must be made 24 hours in advance of any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. If you do not show for your scheduled appointment, your account may be charged a "No-Show" fee.*