

## Patient Information

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_, Last Name: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female                      Date of Birth: \_\_\_/\_\_\_/\_\_\_                      Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Address (home):    Street: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Dentist: \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: (H) \_\_\_\_\_ (C) \_\_\_\_\_

<b>MEDICAL INSURANCE:</b>	<b>DENTAL INSURANCE:</b>
Company:	Company:
Address:	Address:
Policy #:	Policy #:
Group #:	Group #:
<b>Name of Insured</b> (Policy Holder):	<b>Name of Insured</b> (Policy Holder):
Insured's Address:	Insured's Address:
Insured's Phone: (H) _____ (W) _____	Insured's Phone: (H) _____ (W) _____
<b>Insured's Employer:</b>	<b>Insured's Employer:</b>
<b>Insured's Date of Birth:</b>	<b>Insured's Date of Birth:</b>
<b>Insured's Social Security #:</b>	<b>Insured's Social Security #:</b>
<b>Patient's Relationship to Insured:</b> Self / Spouse / Child	<b>Patient's Relationship to Insured:</b> Self / Spouse / Child

(Over)

*If you are under 18 or a full time college student, please fill out the following information:*

Mother's Name: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Address:  
\_\_\_\_\_

Mother's Social Security #: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Address:  
\_\_\_\_\_

Father's Social Security #: \_\_\_\_\_

Who came with you to your appointment today?: Mother / Father / Other \_\_\_\_\_

**Dr. Snyder IS NOT PART OF ANY HMO INSURANCE PLANS**

I certify that the information on this form is correct. I understand that I am responsible for any balance on this account, even if I have medical or dental coverage. Dr. Snyder's office will be happy to assist in filling your insurance claim, but this will not be a substitute for payment. This signature also authorizes Dr. Snyder's office to release any information for insurance purposes. I hereby authorize payment directly to Dr. Snyder.

All Fees Are Due at Time of Service.

Signature of Patient (if over 18): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_