FRICK & JONES, P.A.
practice limited to periodontics

PATIENT INFORMATION

Today's Date: ________________ Last Name:_____________________ First Name: _____________________ Initial: ________

Name by which you would like to be called: ____________________________________ Email: _____________________________

Street Address: __________________________________City _________________________ State & Zip ____________________

Mailing Address (if different from above) ____

Home Phone: _____________________ Work Phone: __________________________ Cell Phone: ________________________

Date of Birth: ________________________ SS#:___________________________ Occupation: ____________________________

Employer: ____ Employer Phone: _______________________

I prefer to be contacted at this number: ____________________________

ALTERNATE INFORMATION

Spouse Name: ____ Home Phone: ______________________________

Work Phone: _____________________________ Cell Phone: ________________________________

Date of Birth: ________________________ SS#:___________________________ Occupation: ____________________________

Employer: ____ Employer Phone: _______________________

Emergency Contact Name: _________________________________ Address: ____

Phone Number: _________________________________ Relationship to Patient: ______________________________

INSURANCE INFORMATION
PRIMARY DENTAL

Employer: __________________________ Insurance Co: __________________________ Group #: ________________

Employee's Name: __________________________ SS #: ______________________ Birthdate: _________________

Employee Id# _______________________

SECONDARY DENTAL

Employer: ______________________________ Insurance Co: __________________________ Group # _____________

Employee's Name: ____________________________ SS# ________________________ Birthdate: ________________

Employee Id# _______________________

Insurance Authorization and Assignment

I hereby authorize Drs. Frick & Jones to furnish information to insurance carriers concerning my treatment and I hereby assign to the periodontist all payments for services rendered to myself or dependents. I understand that I am responsible for payment at time of service and that my insurance will be filed as a courtesy on my behalf.

Signature of Policyholder: ____