*Welcome to Ponchatoula Family Dentistry*

## Patient Information

Date_____ Soc. Sec#_____ Birthdate_____
Name_____ Home Phone_____
Last Name First Name MI
Address_____ Cell Phone_____
City_____ State___ Zip_____ Email_____
Sex: [] Male [] Female [] Married []Single [] Divorced [] Seperated
Primary Language Spoken_____
Employer_____ Business Phone_____
Occupation_____
Who should we thank for referring you?_____
In case of an emergency, who should we contact?_____ Phone_____

## Primary Insurance

Are you the legal guardian of the patient? [] YES or [] NO If no, Name of legal guardian
Person Responsible for Account_____
Last Name First Name MI
Relationship to Patient_____ Birthdate_____ Soc. Sec#_____
Address_____Home Phone_____
City_____ State____ Zip_____ Cell Phone_____
Employer_____ Business Phone_____
Insurance Company_____ Address_____
City_____ State_____ Zip_____
Group#_____ Member ID_____

## Additional Insurance

Relationship to Patient_____ Birthdate_____
Soc. Sec#_____
Address_____ Home
Phone_____
City_____ State____ Zip_____ Cell
Phone_____
Employer_____ Business Phone_____
Insurance Company_____Address_____
City_____ State_____ Zip_____
Group#_____ Member ID_____

## Assignment and Release

I hereby authorize payment directly to Douglas M. George, DDS/Ponchatoula Family Dentistry of all insurance benefits otherwise payable to me for all services rendered. I understand that I am financially responsible for charges that are not paid by my insurance. I authorize the above facility/doctor to release the information required to secure the payment of benefits.
Name_____ Date_____