



HUNTINGTON DENTAL GROUP

William T Myers DDS Inc



Patient # _____

Date _____

PATIENT INFORMATION

Name _____ **Birthdate** _____ **SS#** _____

Street Address _____ City _____ State _____ Zip _____

Sex M F Single Married Widowed Separated Divorced Partnered Minor

Home Phone # () _____ Cell Phone #1() _____ Cell Phone #2 () _____

Employer _____ Employer Phone () _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone() _____

E-Mail _____ Drivers License _____

Person to contact in case of emergency _____ Phone () _____ Referred by: _____

RESPONSIBLE PARTY (Parent/Guardian if Patient is Dependent)

Name of Person Responsible for this Account _____ Birthdate _____ Drivers License _____

Address _____ Home Phone () _____ Relation to Patient _____

Employer _____ Currently a patient in our office? Yes No

E-Mail _____ Work Phone() _____ Cell Phone() _____

INSURANCE INFORMATION - Primary

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # () _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE - Secondary &/or Medical

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # () _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

Authorizations

I certify that I am covered by the above insurance and I assign directly to Huntington Dental Group &/or William T Myers, DDS. Inc. all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and that I am responsible for payment of any co-payment and deductible that my insurance does not cover. I hereby authorize arelease of all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic

Signature _____ Date _____

This office HIPAA compliant and is committed to meeting or exceeding the standards of infection control as mandated by OSHA, the CDC and the ADA