

PATIENT INFORMATION FORM

Steven R. Hecklin, D.M.D.
Cosmetic and Restorative Dentistry

Name _____ Date of Birth _____

Home Address _____ Zip Code _____ Home Phone _____

Email Address _____ Cell Phone _____

Place of Business _____ SS# _____

Business Address _____ Zip Code _____ Telephone _____

Who may we thank for referring you to us? _____

Marital Status _____ Spouse _____

Spouse's Employer _____ SS # _____

Business address _____ Zip Code _____ Telephone _____

Emergency Contact:

Name _____ Relationship _____ Phone hm wk

Dental Insurance (Primary)

ID # _____

Insurance Company name _____ Group # _____

Insurance Company Address _____

_____ Zip Code _____ Telephone _____

Employee _____ SS# _____ Date of Birth _____

Employer Name _____

Employer Address _____ Zip Code _____ Telephone _____

Dental Insurance (Secondary)

ID # _____

Insurance Company name _____ Group # _____

Insurance Company Address _____

_____ Zip Code _____ Telephone _____

Employee _____ SS# _____ Date of Birth _____

Employer Name _____

Employer Address _____ Zip Code _____ Telephone _____

I authorize the release of any information necessary to process my insurance claim and authorize payment directly to the dentist of the insurance benefits otherwise payable to me. I agree to release my social security number to Dr. Hecklin should additional collection measures be needed on any unpaid balance. A copy of this signature is as valid as the original.

Our office policy is to accept payment at the time services are rendered unless arrangements are made in the front office in advance. We are happy to file your dental insurance for you. If you have any questions please let us know.

I realize that, regardless of insurance benefits, I am financially responsible for all services rendered, including any collection and/or attorney fees if necessary.

Signature _____ Date _____