Patient Information

First Name: _____ Last Name: _____ Middle Initial:_____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Soc. Sec: _____

Home Phone: _____ Work Phone:_____ Ext:_____

Mobile Phone:_____ Drivers Lic: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

If referred by someone whom may we thank for the referral? _____

Email Address: _____

☐ I would like to receive correspondences via Email

☐ I would like to receive correspondences via Text Message

Primary Insurance Information

Name of Insured: _____ Employer Name: _____

Insured Address: _____ Insured Birth Date: _____

Ins. Company: _____ Relationship to Insured: ☐ Child ☐ Other ☐ Spouse ☐ Self

Insured Soc. Security: _____

Insurance ID Number: _____ Ins. Company Phone Number: _____

Insurance Address: _____ Ins. Company Website: _____

City, State, Zip: _____

Student Status: ☐ Full Time ☐ Part Time Name of College/University: _____

Secondary Insurance Information

Name of Insured: _____ Employer Name: _____

Insured Soc. Security/ID Number:_____ Insured Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Ins. Company: _____ Ins. Company Phone Number: _____

Address: _____ Ins. Company Website: _____

City, State, Zip: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Robert J Stevenson DDS, PC all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

Responsible Party Signature: _____

Relationship: _____ Date: _____