PINE BELT PERIODONTICS, PLLC

Today's Date: _____

Patient Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Height ____ Weight ____ Single ____ Married ____ Widowed ____ Divorced ____

SS# _____ Occupation _____ Employed By _____

Name of Spouse/Parent _____ Occupation _____

Spouse/Parent Employer _____ Phone _____

Spouse/Parent SS# _____ Date of Birth _____

Whom may we thank for referring you to this office _____

City and State _____

Dental Insurance _____ ID # _____
Address _____ Phone # _____
Insured's Name _____ Group # _____

I authorize Pine Belt Periodontics, PLLC, to verify benefits, file claims and receive payment from my insurance company.

Signature _____ Date _____

I give Pine Belt Periodontics permission to discuss my medical and dental information with the following people:

1) _____
2) _____