ZYSIK FAMILY DENTAL **10/16**

PATIENT INFORMATION

Date________________

Patient Name______________________________MI_________ Date Of Birth______________________

Address_________________________________ Apt#____

City___________________________________ State______________________Zip__________________

Male <> Female <>

CONTACT INFORMATION

Home_____________________ Cell__________________________

Is it okay to leave a message on the phone numbers that you have provided <> Yes <> NO

Do you want to receive text message as a reminder for future appointments <> Yes <> No

Work#______________________Employer_____________________________

Can we contact you at work about future appointments <> Yes <> No

Email____

Would you like to receive email messages as a reminder for future appointments <> Yes <> No

Pharmacy____

PRIMARY INSURANCE INFORMATION - RESPONSIBLE PARTY

Subscriber Name____

Relationship to patient <> Self <>Spouse <> Parent <> Other

Subscriber Date of birth __________________________________

Subscriber Employer ____________________________________

Subscriber SSN____

Subscriber ID#____

SECONDARY INSURANCE INFORMATION

Subscriber Name____

Relationship to patient <> Self <>Spouse <> Parent <> Other

Subscriber Date of birth __________________________________

Subscriber Employer ____________________________________

Subscriber SSN____

Subscriber ID#____

MEDICAL INSURANCE

Subscriber Name____

Relationship to patient <> Self <>Spouse <> Parent <> Other

Subscriber Date of birth __________________________________

Subscriber Employer ____________________________________

Subscriber SSN____

Subscriber ID#____

EMERGENCY CONTACT INFORMATION

In case of emergency, please provide emergency contact information:

Name____ Telephone__________________________________

Relationship____

Assignment and release: I certify that I, and/or my dependent(s) have insurance coverage with the above named insurance company(ies) and assign directly to Dr. Edmund T. Zysik Jr. all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Edmund Zysik Jr. may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient with the above named medical/dental facility.

Pt Signature/Responsible Party:____