DLS DDS
STOLZENBURG
FAMILY & COSMETIC
DENTISTRY

ID:
CHART ID:

First Name: Last Name: Middle:
Patient is : Policy Holder Responsible Party Preferred Name:

Patient Information

Address City State Zip
Home Phone: Work Phone: Ext: Cell Phone:
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birthdate: Age: Social Security: Drivers License:
Email: Yes, I would like to receive correspondence in the form of an email
Who should we thank for referring you?

Section 2

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Employer:
Occupation:

Section 3

Physician's Name:
Physician's Phone:
Emergency Name:
Emergency Number:

Responsible Party

First Name: Last Name: Middle:
Address City State Zip
Home Phone: Work Phone: Ext: Cell Phone:
Birthdate: Age: Social Security: Drivers License:
Employer: Employer Address:

Primary Insurance Information

Name of Insured Relationship to Insured Self Spouse Child Other
Insured Social Security Insured Birthdate: ID#: GROUP#:

Employer
Address
City, State Zip
Phone #

Insurance Company
Address
City, State Zip
Phone #

Secondary Insurance Information

Name of Insured Relationship to Insured Self Spouse Child Other
Insured Social Security Insured Birthdate: ID#: GROUP#:

Employer
Address
City, State Zip
Phone #

Insurance Company
Address
City, State Zip
Phone #

ASSIGNMENT AND RELEASE

I hearby authorize payment directly to Dr Stolzenburg for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date