RONALD L. MCKAY, D.D.S
JERRY J. ALBUS, D.D.S.
VICKIE LAI, D.D.S

PATIENT INFORMATION (Confidential)

Name _____Date_____
First MI Last

Address_____City_____State_____Zip_____

Home_____Cell_____Work_____Email_____

Driver's License #_____SS#_____Birthdate_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Patient's or Parent's/Guardian's employer_____

Occupation_____

Employer Address_____City_____State_____Zip_____

Spouse's Name _____Employer_____Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____Phone_____

RESPONSIBLE PARTY

Name of person responsible for this account_____Relationship to patient_____

Address_____Home Phone_____

Driver's License #_____Birthdate_____SS#_____

Employer _____Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured_____Date_____

SS#_____Birthdate_____

Name of Employer_____Union or Local# _____Work Phone_____

Employer Address_____City_____State_____Zip_____

Insurance Co. _____Phone#_____Grp #_____ ID#_____

Insurance Co. Address_____City_____State_____Zip_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured_____Date_____

SS#_____Birthdate_____

Name of Employer_____Union or Local# _____Work Phone_____

Employer Address_____City_____State_____Zip_____

Insurance Co. _____Phone#_____Grp #_____ ID#_____

Insurance Co. Address_____City_____State_____Zip_____

AUTHORIZATION AND RELEASE

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information I may have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X_____

Signature of Patient (or parent/guardian, if minor) Date