CASTOR FAMILY DENTISTRY

PATIENT INFORMATION

_____

Last Name First Name M.I. DOB

PATIENT INFORMATION

Social Security #: _____ Driver's License #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

Marital Status: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient/Guardian's Employer: _____ Occupation: _____

Spouse/Guardian's' Name: _____ Contact Number: _____

RESPONSIBLE PARTY [ ] Same as above

Name of Person Responsible for Account: _____ Relationship: _____

Social Security #: _____ Driver's License #: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Social Security #: _____

Policy Holder Employer: _____ Work Phone: _____

Insurance Co.: _____ Group # _____ Policy/ID#: _____

Do you have any additional dental insurance? [ ] Yes [ ] No

Authorization and Release of Information

I agree that Castor Family Dentistry may bill my insurance carrier for the service provided, as a courtesy to me, and that all payments will come directly to C. Brandon Castor, DDS at Castor Family Dentistry. I understand that I am solely responsible for the cost of my dental treatment. I hereby give authorization for the release of any information requested/ required by my insurance company with respect to any insurance claims.

Patient/ Guardian Signature: _____ Date: _____