

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Business: _____

Have you seen Dr. Monson previously? Yes No If Yes, When _____

Has a family member seen Dr. Monson previously? Yes No If Yes, who _____

Male Female Marital Status: married / single / divorced / widowed

Social Security No.: _____ Date of Birth: _____

Physician's Name: _____ Address: _____ Phone: _____

Dentist's Name: _____ Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION: Patient is responsible party (skip to insurance information)

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Business: _____

Male Female Marital Status: married / single / divorced / widowed

Social Security No.: _____ Date of Birth: _____

INSURANCE INFORMATION: Do You Have Dual Insurance Coverage? Yes No

Subscriber's Name: _____ Social Security Number: _____

Employer: _____ Business Address: _____

Business Phone No.: _____ Relationship to Patient: Self / Spouse / Parent / Child

Dental Insurance Co.: _____ Group# _____ Plan# _____

Address of Insurance Co: _____ Phone number: _____

Medical Insurance Co.: _____ Group# _____ Plan# _____

Address of Insurance Co: _____ Phone number: _____

Who were you referred by? _____

Name of person completing this form: _____

Dr. Monson's office will follow accepted guidelines to keep my private health information confidential. I understand that my private health information may be released to insurance carriers and to other medical practitioners in the course of treatment and billing. I authorize Dr. Monson's office to obtain my private health information from other practitioners. I authorize payment to Dr. Monson the insurance benefits otherwise payable to me. I agree to be financially responsible for this account.

Signature: _____ Date: _____