

PATIENT INFORMATION:

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
MAILING ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DRIVER'S LICENSE: \_\_\_\_\_
PHYSICAL ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_
IF SAME AS MAILING, WRITE "SAME"
EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_
WHAT NUMBER WOULD YOU LIKE US TO CONTACT YOU AT: \_\_\_\_\_

- YES NO IF MARRIED, DO YOU AND YOUR SPOUSE REQUIRE A SEPARATE ACCOUNT
MINE SPOUSE IF YOU HAVE CHILDREN AND HAVE SEPARATE ACCOUNTS, WHICH ACCOUNT ARE THE CHILDREN ON

IF YOU ARE A FULL-TIME STUDENT LIST UNIVERSITY & CITY: \_\_\_\_\_
WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: \_\_\_\_\_

GUARANTOR: (PERSON RESPONSIBLE FOR PAYMENT) IF SAME AS ABOVE, WRITE "SAME"

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DRIVER'S LICENSE: \_\_\_\_\_
EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SPOUSE INFORMATION: IF SAME AS GUARANTOR, WRITE "SAME"

SPOUSE'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DRIVER'S LICENSE: \_\_\_\_\_
SPOUSE'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

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PRIMARY INSURANCE:

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_
GROUP NUMBER: \_\_\_\_\_ I.D. NUMBER (OR SSN): \_\_\_\_\_
NAME OF SUBSCRIBER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SECONDARY INSURANCE:

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_
GROUP NUMBER: \_\_\_\_\_ I.D. NUMBER (OR SSN): \_\_\_\_\_
NAME OF SUBSCRIBER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ASSIGNMENT AND RELEASE:

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH \_\_\_\_\_ AND
ASSIGN DIRECTLY TO DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO
ME 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. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR
THIS OFFICE AND GIVE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT
ACTIVITIES, AND HEALTHCARE OPERATIONS. I AUTHORIZE AND GIVE CONSENT FOR DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, TO
CONTACT MY EMPLOYER TO VERIFY EMPLOYMENT AND ANY OTHER INFORMATION NEEDED TO VERIFY INSURANCE ELIGIBILITY AND BENEFITS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_