PATIENT INFORMATION:

NAME:_____ DATE OF BIRTH:_____

HOME ADDRESS:_____ CITY:_____STATE: ____

ZIP CODE: _____ E-MAIL: _____ SSN:_____

HOME PHONE:_____ CELL PHONE: _____

PREFERRED METHOD OF CONTACT?: _____

EMPLOYER:_____ WORK PHONE _____

EMERGENCY CONTACT: _____ PHONE NUMBER:_____

PRIMARY INSURANCE INFORMATION: SUBSCRIBER'S

NAME:_____RELATIONSHIP TO INSURED: self/ spouse /child/other

SUBSCRIBER DOB:_____INSURANCE CARRIER:_____

NUMBER:_____ GROUP NUMBER:_____

INS.ADDRESS: _____ INS. PHONE #:_____

SECONDARY INSURANCE INFORMATION: SUBSCRIBER'S

NAME:_____ RELATIONSHIP TO INSURED: self spouse child other

INSURANCE CARRIER:_____

ID NUMBER:_____ GROUP NUMBER:_____

INS. ADDRESS:_____

CITY, STATE, ZIP CODE:_____ INS. PHONE #_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: _____

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. KARLA AYLEN DDS. I UNDERSTAND THAT I ASSUME THE ULTIMATE RESPONSIBILITY FOR PAYMENT OF SERVICES. I WILL BE BILLED FOR SERVICES IN ACCORDANCE TO THE FEE SCHEDULE IN USE AT THE TIME SERVICES ARE RENDERED. THERE IS A FEE FOR ALL BROKEN APPOINTMENTS WITHOUT TWO BUSINESS DAYS' NOTICE. OUR REMINDERS ARE ONLY A COURTESY; PATIENTS MUST BE RESPONSIBLE FOR ALL APPOINTMENTS MADE.

SIGNATURE:_____ DATE: _____