WOODBURY IMPLANT SEDATION AND ORAL SURGERY

RICHARD PIHLSTROM, D.D.S.

Personal Information

First Name _____ M.I. _____ Last Name _____

Date of Birth _____ Marital Status: Single ____ Married ____ Sex: Male ____ Female ____

Home Address _____

City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail _____

Referred By _____

I.e. dentist (name & clinic), friend (name), website, google, etc.

Emergency Contact

Name _____ Phone _____

Insurance Information

Primary Insurance

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's ID or Social Security No. _____ Group No. _____

Subscriber's Employer _____

Secondary Insurance

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's ID or Social Security No. _____ Group No. _____

Subscriber's Employer _____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I understand that I am responsible for payment regardless of insurance coverage, and that finance charges will be applied to balances over 60 days. Credit bureau reports may be obtained. I verify I have received a copy of the Notice of Privacy Practices, and consent to your use of my protected health information

Signature of Patient / Parent _____ **Date** _____