STELZERDENTAL
AESTHETIC AND GENERAL DENTISTRY

ABOUT YOU

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

Preferred Name: _____ Age: _____ Date of Birth: _____ Sex: ____ Male ____ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Marital Status: ____ Married ____ Single ____ Divorced ____ Separated ____ Widowed

Occupation: _____ Employer: _____

Email: _____ ***May we contact you via email? (Please Circle) Yes No***

Whom should we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT

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

Relationship of responsible party to patient: ____ Self ____ Spouse ____ Father ____ Mother ____ Guardian

If responsible party is other than patient, please complete the remainder of this information.

Address: _____ City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City, State, Zip: _____

Insurance Co Phone #: _____

Group/Plan #: _____

ID #: _____

Insured's Name: _____

Relationship to Insured: ____ Self ____ Spouse ____Child ____ Other

Insured's DOB: _____

Insured's SSN#: _____

Insured Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City, State, Zip: _____

Insurance Co Phone #: _____

Group/Plan #: _____

ID #: _____

Insured's Name: _____

Relationship to Insured: ____ Self ____ Spouse ____Child ____ Other

Insured's DOB: _____

Insured's SSN#: _____

Insured Employer: _____

Consent: The undersigned hereby authorizes the Doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk. I understand that my dental insurance is a contract between the insurance carrier, and me and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time of services rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balances.

_____ _____

Signature of Patient, Parent, or Guardian Date