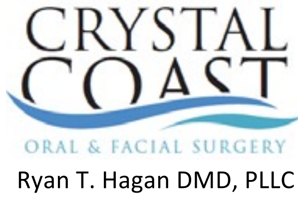

Ryan T. Hagan DMD, PLLC

SECTION I: PATIENT INFORMATION

Name ______________________________Preferred Name____________ ___ Male ☐ Female ☐

Address ______________________________City____________ State_______ Zip_________

Home Phone# (_____)____________ Cell Phone# (_____)____________ Work Phone# (_____)____________

Soc. Sec. No. ______________ Date of Birth ____________ Age _________ Employer ____________

Martial Status ____________ Spouse Name ____________ Full Time Student? YES NO If so, where? ____________

Emergencey Contact Name: ______________________ Emergency Contact Phone #: ______________

Who is responsible for your account? ☐ Self **(If self, skip to Section III)** ☐ Spouse ☐ Father ☐ Mother ☐ Other **(Please complete Section II)**

SECTION II: INSURED INFORMATION/PERSON FINANCIALLY RESPONSIBLE RELATION TO PATIENT ____________

Name ______________________________ Male ☐ Female ☐ Email ______________________

Address ______________________________ City____________ State______ Zip_________

Home Phone# (_____)____________ Work Phone# (_____)____________ Employer ______________

Soc. Sec. No. ______________ Date of Birth ______________ Age ______ Occupation ______________

Marial Status ______ Spouse Name ______________ Occupation ____________Work Phone #(_____)____________

SECTION III: INSURANCE INFORMATION

(Please provide insurance card(s) for photocopying.)

Primary Dental:
Insurance Carrier: ______________________
Claims Address: ______________________
____
Phone# (_____)______________________
Patient ID # ______________________
Group # ______________________

Primary Medical
Insurance Carrier: ______________________
Claims Address: ______________________
____
Phone# (_____)______________________
Patient ID # ______________________
Group # ______________________

Secondary Dental:
Insurance Carrier: ______________________
Claims Address: ______________________
____
Phone# (_____)______________________
Patient ID# ______________________
Group # ______________________

Secondary Medical:
Insurance Carrier: ______________________
Claims Address: ______________________
____
Phone# (_____)______________________
Patient ID# ______________________
Group # ______________________

Whom may we thank for referring you to our office? ______________________________
Dentist's Name: ______________________ Physician Name/Phone# ______________________

I agree that all information above, is truthful and accruate and that I have been provided with a copy of this office's notice of "Privacy Practices". All charges are due and payable the day of services unless written preauthorization has been obtained. We will gladly provide and submit insurance forms for you. Regardless of insurance benefits, you are ulitmately responsible for all charges incurred in this office. I authorize the following signatures to be kept as "signature on file" and used for insurance and payment purposes.

______________________ ______________________ ______________________
Patient Signature Date **Guarantor Signature** Date **Relationship to Patient**