Ron Freeman, D.D.S.

Date _____

PATIENT INFORMATION

Mr. / Mrs. / Ms. / Child Sex: M / F

❑ Married ❑ Divorced ❑ Single
❑ Widowed ❑ Domestic Partner

_____
Last Name First Name Middle Name

Preferred Name _____ Birthdate_____ SS# _____ - _____ - _____

Patient Address _____ Drivers License # _____
Street City Zip

Employer: _____ Occupation: _____

Employer Address: _____
Street City Zip

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____ Referred by: _____

Emergency Contact: _____Relationship_____ Phone: (_____) _____

Special Interests or Hobbies (i.e., sports, self-improvement) _____

ACCOUNT INFORMATION

Person Responsible for Account *(if different from above)*

_____ Mr. / Mrs. / Ms.
Last Name First Name Middle Name

Mailing Address _____
Street City State Zip

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

SS# _____ - _____ - _____ Drivers License # _____ Date of Birth _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City Zip

Spouse _____ Occupation _____

Employer: _____
Company Street City State Zip

SS# _____ - _____ - _____ Drivers License # _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

INSURANCE INFORMATION

Insurance Company #1 _____ Group / Policy No. _____

Insurance Company #1 Address _____

Policyholder Name _____ S.S. # _____ - _____ - _____ Date of Birth _____

Insurance Company #2 _____Group / Policy No. _____

Insurance Company #2 Address _____

Policyholder Name _____ S.S. # _____ - _____ - _____ Date of Birth _____

• IF A THIRD INSURANCE POLICY NUMBER IS APPLICABLE, PLEASE NOTIFY US •

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician, of insurance benefits under which I am entitled.

_____ _____
Signature of Patient Signature of Responsible Party

APPOINTMENTS: A minimum charge will be made for failed or canceled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has be to paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you. Prepayment will be required to reschedule failed appointments.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.