PATIENT INFORMATION AND HEALTH HISTORY

Welcome to Dr. Paulisin's office! To assist us in serving you, please complete the following confidential forms.

PATIENT Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date_____Email_____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Responsible Party / Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

I understand that I am responsible for the timely payment of my account. A late fee and/or interest at the rate of 1.5% per month on unpaid balances may be charged on all account exceeding 90 days unless other financial arrangements have been agreed upon. Accounts that remain unpaid for more than 120 days may be subjected to collection proceedings and any costs related to such collection attempts will be added the account balance. I also understand that I will be charged $40 for an appointment broken without 24 hours notice.

I agree that assignment of benefits from my insurance will be paid directly to Dr. David A. Paulisin, DDS.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:
Signature of guarantor of payment/responsible party