WELCOME

Thank you for selecting our office! To help us process your insurance correctly, please fill out this form completely and notify us of any changes. We are happy to help, if assistance is required.

Patient Information:

Last Name: ______________ First Name: ______________ Middle Initial: ______ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

I prefer to be called: ______________ E-mail Address: ______________

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Date of Birth: ______________

Minor: ☐ Yes ☐ No Name of School: ______________ Full-time Student: ☐ Yes ☐ No

Responsible Party Information:

Last Name: ______________ First Name: ______________ Date of Birth: ______________

Soc. Sec. #: ______________ Relationship to Patient: ______________

Home Address: ______________ Apt. No.: ______________

City: ______________ State: ______________ Zip: ______________

Home #: ______________ Cell #: ______________ Work #: ______________ Ext: ______

Name of Employer: ______________ Occupation: ______________

Insurance Company: ______________ Phone #: ______________

Additional Insurance Information:

Last Name: ______________ First Name: ______________ Date of Birth: ______________

Soc. Sec. #: ______________ Relationship to Patient: ______________

Home Address: ______________ Apt. No.: ______________

City: ______________ State: ______________ Zip: ______________

Home #: ______________ Cell #: ______________ Work #: ______________ Ext: ______

Name of Employer: ______________ Occupation: ______________

Insurance Company: ______________ Phone #: ______________

Nearest Relatives

Last Name: ______________ First Name: ______________ Phone#: ______________

Last Name: ______________ First Name: ______________ Phone#: ______________

Who May We Thank For Referring You?

☐ Referred by a Friend (Name of the person we can thank) ______________

☐ Other (Please Specify) ______________

Agreement To Pay:

I understand that I am responsible for payment of services rendered and also am responsible for paying any co-payment and deductibles not covered by my insurance. I hereby authorize payment directly to Galina Nasakin DDS. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE: ______________ DATE: ______________