# PATIENT INFORMATION FORM

**Date:** ______/_____/________________
Month Day Year

**Purpose of Appointment:** ____________________________________________

**Referred By:** ____________________________________________

**Name:** ____________________________________________
Last First Middle

**Date of Birth:** ___________/__________/_______________
Month Day Year

**Social Security Number:** ________-_____________-_________________________

**Driver's License Number:** ____________________________________________

**Home Address:** ____________________________________________
Street City State Zip Code

**Preferred Contact Telephone Number(s):** (________)__________________________(________)____________

**Parent or Guardian (if applicable):**____________________________________________

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

**Occupation:** ____________________________________________

**Employer:** ____________________________________________

**Business Address:**____________________________________________
Street City State Zip Code

**Business Telephone:** (________)____________________________

**Spouse's Name (if applicable):** ____________________________________________

**DENTAL INSURANCE**

**Name of Insurance:**____________________________________________

**Insured's Name:** ____________________________________________

**Relationship of Insured to Patient:** ____________________________________________

**Insured's ID #:** ________________________________ **Insured's Group #:** ______________________

**Insured's Date of Birth:** _________/_____/

**Insured's Employer:** ____________________________________________

**MEDICAL INSURANCE**

**Name of Insurance:** ____________________________________________

**Insured's Name:** ____________________________________________

**Relationship of Insured to Patient:** ____________________________________________

**Insured's ID #:** ________________________________ **Insured's Group #:** ______________________

**Insured's Date of Birth:** _________/_____/

**Insured's Employer:** ____________________________________________

**I Give Permission for Information to be Released to the Insurance Company:**

**Signature:** ____________________________________________

**I Give Permission to Assign My Insurance Benefits to the Doctor:**

**Signature:** ____________________________________________

The payment of charges for which patients' are responsible (those charges not covered by insurance) are expected at the time any service is rendered. This can include, but is not limited to deductibles, co-insurance and non-contracted services. Medical and/or dental insurance can be submitted by the office to compensate either the patient for non-contracted insurers, or Dr. Montgomery in cases of where the insurance company is contracted with us. Missed appointments and appointments not cancelled with at least 24 hours notice may be subject to a $50 cancellation fee.

**Signature of person responsible for the account:** ____________________________________________