David A. Tecosky, DMD

Registration Date _____

Patient Name _____ I prefer to be called _____

Sex: Male/Female Marital Status: Married/Single/Divorced/Widowed/Other Title: Dr./Mr./Mrs./Ms./Miss

Date of Birth _____/_____/_____ S.S. # _____ - _____ - _____

Address: _____
(House#/Street Name/Apt#)

_____
(City/State/Zip)

Contact Information (2 phone #'s and an email):

Phone # _____ (H/W/M) Phone # _____ (H/W/M)

E-Mail _____

If patient is a minor:

Parent/Guardian Name _____ Relationship _____

****

Emergency Contact:

_____ _____ _____
Name Relationship Phone #

****

Please list household members

_____ _____ _____

_____ _____ _____

****

Do you have dental insurance? Y/N Name of Insurance _____

Is Patient a student? Y/N Full/Part time? Where? _____

Employer: _____ Occupation: _____

Business Address: _____

****

Who may we thank for referring you to our office? _____

How may we help you today? _____

_____

The information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

_____ _____
Signature Date

Insurance Information

	Primary Insurance Information	Secondary Insurance Information (if applicable)
Subscriber Name	_____	_____
Subscriber Date of Birth	_____	_____
Patient Relationship to Subscriber	_____ ____	_____
Address/Phone# (If different from patient)	_____	_____
	_____	_____
	_____	_____
Employer Name	_____	_____
Employer Address	_____	_____
	_____	_____
Employer Phone #	_____	_____
SS/ID #	_____	_____
Group#	_____	_____
Insurance Co. Name	_____	_____
Insurance Co. Address	_____	_____
	_____	_____
Insurance Co. Phone #	_____	_____

Insurance benefit authorization

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with any claim submitted by this office.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. David A. Tecosky.

_____ _____

Signature of patient/guardian/subscriber Date