

JEFFREY L. ELMER, D.D.S.
 172 ALLCUTT
 BONNER SPRINGS, KANSAS 66012
 Telephone (913) 422-3011

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Best way to contact you: H W C Phone E-mail Text message

Home Phone No. _____

Work Phone No. _____

Cellular Phone No. _____

E-mail Address _____

Birth date _____ Age _____ Male Female

Social Security Number _____

Married Single Divorced Widowed

Employer _____ Position _____

School _____

The best time for your appointments are at:
 _____ AM _____ PM

The best day of the week is: (circle one or more)
 M T W T R

Emergency Contact Information:

Name _____

Relationship _____

Phone Number _____

Address _____

City _____ State _____ Zip _____

Who may we thank for referring you:

Friend's Name

Sign

Website/Internet Search

Newspaper

Television

Other

Responsible Party

Address _____

City _____ State _____ Zip _____

Responsible Party Social Security Number _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE Group# _____ Policyholder ID# _____

Insurance Company _____ Insurance Company Address(P.O.Box/Street) _____

Insurance Company Phone _____ Policy Holder _____ City _____ State _____ Zip _____

Policy Holder's Birthdate _____ Policy Holder's Social SecurityNo. _____ Persons covered under this policy _____

Employer Name _____

Employer Address _____ Employer Phone _____

SECONDARY INSURANCE Group# _____ Policyholder ID# _____

Insurance Company _____ Insurance Company Phone _____ Insurance Company Address (P.O. Box/Street) _____

Policy Holder _____ Persons Covered Under This Policy _____ City _____ State _____ Zip _____

AUTHORIZATION/RELEASE OF INFORMATION. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE OF RESPONSIBLE PARTY

Adult Patient Father (or husband) Mother (or wife) Guardian

Date _____ State Driver's License Number _____