

Mark I. Degen, D.D.S., M.D.
Red Rock Oral and Maxillofacial Surgery Centre

Patient Information

NAME: _____ Preferred to be called: _____

LAST FIRST MI

ADDRESS: _____

STREET APARTMENT #

CITY STATE ZIP CODE

PHONE (HOME): _____ (WORK): _____ EXT: _____ (CELL): _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

TREATING DENTIST: _____ PHONE: _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE/HOW DID YOU HEAR ABOUT US? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? _____

I WILL BE PAYING TODAY BY CASH CHECK CREDIT CARD

CREDIT CARD TYPE VISA MC AMEX CARECREDIT CARD# _____ EXP: _____

Primary Dental Insurance Policy Holder Information

NAME: _____

LAST FIRST MI

POLICY HOLDER BIRTH DATE _____ SSN OR ID# _____ GROUP# _____

POLICY HOLDERS ADDRESS _____

STREET CITY STATE ZIP CODE

POLICY HOLDERS EMPLOYER NAME: _____ EMPLOYERS ADDRESS: _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

INSURANCE COMPANY NAME: _____ INS. COMPANY PHONE # _____

Secondary Dental Insurance Policy Holder Information

NAME: _____

LAST FIRST MI

POLICY HOLDER BIRTH DATE: _____ SSN OR ID#: _____ GROUP#: _____

POLICY HOLDERS ADDRESS _____

STREET CITY STATE ZIP CODE

POLICY HOLDERS EMPLOYER NAME: _____ EMPLOYERS ADDRESS: _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

INS. COMPANY NAME: _____ INS. COMPANY PHONE # _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature/Parent or Legal Guardian if minor

Date