JOSEPH J. KURTIS, DMD

fine restorative and cosmetic dentistry

PATIENT INFORMATION

DATE _____

Name _____ ❑Married ❑ Single ❑ Minor ❑ Male ❑ Female
First M. Last

Address _____
Street Apt# City State Zip

Birth Date _____ Soc. Sec # _____

Telephone (Home) _____ (Cell) _____ (Pager) _____

(Work) _____ x _____ (E-mail) _____ _____

What would you like to be called? _____ Pharmacy _____ Tel # _____

Employment Status ❑Full Time ❑Part Time ❑Retired

Employer _____

Address _____

Student Status ❑Full Time ❑Part Time

School _____

City _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____

City _____ St _____ Zip _____

Telephone (Home) _____

(Cell) _____

DENTAL INSURANCE

Cardholder Name: _____
Cardholder Soc. Sec. #: _____
Cardholder Birth Date: _____
Relationship to Patient: _____
Cardholder's Employer: _____
Address: _____
City: _____
State, Zip: _____

Insurance Name: _____
Address: _____
City, State, Zip: _____
Policy ID #: _____
Group#: _____

Whom may we thank for referring you to our office?

_____

PAYMENT INFORMATION

It is the policy of this office to request payment at the time of your visit. You will be provided with an itemized statement that is satisfactory for insurance purposes.

Private insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered changes, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

_____ _____
Patient Signature Date

State Driver's License # : _____

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