WARK
DENTAL GROUP

ACQUAINTANCE FORM

Patient's Name _____ Preferred to be called _____

Address _____
Street City State Zip Code

Employer _____ Occupation _____

Phone (Home): _____ (Work): _____ (Cell): _____

Birthdate _____ Soc Sec # _____ Email _____

Sex _____ Marital Status: S _____ M _____ W _____ D _____

How did you hear about our practice? _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Name _____ Relationship to Patient _____

Address _____
Street City State Zip Code

Employer _____ Occupation _____

Phone (Home): _____ (Work): _____ (Cell): _____

Primary Insurance Information

Name of Insured _____ Employer _____

Insured's Birth Date _____ Soc Sec # _____ Insurance ID # _____

Patient's Relationship to Insured - Self _____ Spouse _____ Child _____ Other _____ Group # _____

Insurance Company Name _____ If Patient is a Student— Name of School _____

Secondary Insurance Information

Name of Insured _____ Employer _____

Insured's Birth Date _____ Soc Sec # _____ Insurance ID # _____

Patient's Relationship to Insured - Self _____ Spouse _____ Child _____ Other _____ Group # _____

Insurance Company Name _____

I authorize the release of any information necessary to process my insurance claim.

X _____

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.