Tell Us About Yourself

FORM 1 of 3 - New patients please complete forms 1 – 3

Legal name: ____ (Circle one) Mr. Mrs. Ms. Miss Dr.

How would you prefer to be addressed? _______________________ (Circle one) Married Divorced Widowed Single

Date of birth: _______________ SS #: _______________________

Address: ____ City: _______________ State: ________ Zip: ________

Home Phone: _______________________ Cell Phone: ______________________ Business Phone: ____________________

Which number should we call first? Home Cell Work Employer/Occupation: ___________________________________

E-mail address: ____

Full time student? NO YES Name of School: ____

Spouse's name: ____ Spouse's Phone: _________________________________

Emergency contact: ___________________________ Phone #: ____________________ Relationship to patient: ____________

Who is your medical doctor? ____ Phone #: _____________________________

Who was your previous dentist? ____ Phone #: ______________________________

Who may we thank for referring you? ____

Primary Dental Insurance (please be prepared to present your insurance card(s) upon your first visit):

Dental Insurance: ____ Group #: ______________________________

Claims Address: ____ City: _______________ State: _______ Zip: ________

Claims Phone #: ____________________________ Subscriber's Employer/Occupation: _________________________________

Subscriber's Name: ____ Relationship to patient: ____________________________

Subscriber's Date of birth: ________________ Subscriber's SS #: ___________________ ID #: ________________________

Secondary Dental Insurance:

Dental Insurance: ____ Group #: ______________________________

Claims Address: ____ City: _______________ State: _______ Zip: ________

Claims Phone #: ____________________________ Subscriber's Employer/Occupation: _________________________________

Subscriber's Name: ____ Relationship to patient: ____________________________

Subscriber's Date of birth: ________________ Subscriber's SS #: ___________________ ID #: ________________________

Authorization and Payment Agreement:

We believe we have a responsibility to provide the best professional care, skill and judgment in planning and delivering your dental treatment. Your payment will reimburse us for our services. By signing below, you are indicating that after all fees are properly explained to you that you agree to fulfill your financial commitment to our office promptly and completely.

I hereby authorize my insurance company to make payments directly to the office of Dr. Glenn D. Krieger. If I should receive an insurance check, and I have an outstanding balance, I agree to immediately endorse and remit the check to the dental office. I understand that I am responsible for all costs of dental treatment regardless of insurance payments or lack thereof. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand any photos taken may be used for educational or promotional purposes by the office of Dr. Glenn D. Krieger.

Signature (if minor, responsible party) ____ Date ________________