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Patient Information:

First Name:________________________ Last Name:____ Middle Int.:____

SSN:___________________DOB:___________ Sex: M / F Marital Status: Single / Married / Divorced / Widowed

Home Phone:____________________ Work Phone: _______________E-mail: ________________________________

Address:____ City:_____________________ State:_____ Zip:_____

Are you the responsible party: Y / N If no please fill out below:

Responsible Party:

First Name:________________________ Last Name:____ Middle Int.:____

SSN:___________________DOB:___________ Sex: M / F Marital Status: Single / Married / Divorced / Widowed

Home Phone:____________________ Work Phone: _______________E-mail: ________________________________

Address:____ City:_____________________ State:_____ Zip:_____

Insurance Information:

Policy holder name:_____________________________ DOB:___________ SSN:_______________ ID#: ____________

Relationship to patient: Self / Spouse / Parent / Other (please specify):____________________________________

Employer:_______________________ Group#:______________ Insurance Company:___________________________

Claims Address:___________________________________ City:_____________________ State:______ Zip:_________

Phone Number:___________________ Is this the only coverage: Y / N if no please fill out below:

Policy holder name:_____________________________ DOB:___________ SSN:_______________ ID#: ____________

Relationship to patient: Self / Spouse / Parent Other (please specify):____________________________________

Employer:_______________________ Group#:______________ Insurance Company:___________________________

Claims Address:___________________________________ City:_____________________ State:______ Zip:_________

I give consent for Jeffrey A. Blankenbeckler DDS, Ltd. To bill my insurance carrier for services rendered and I understand that I am ultimately responsible for any outstanding balances on my account:

Signature:____ Date:________________________

Printed Name:____ Relation to patient:___________________