

Spokane Dental | Dr. Trason Shoquist DMD

I. PATIENT INFORMATION

Today's Date _____

Patient Name _____

Last

First

Middle Initial

Home Address _____ City _____ State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Please circle which number is best daytime contact for you

E-mail address _____ Birthdate _____ Soc. Sec # _____

Occupation _____ Employer _____ Marital Status _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____

Who should we contact in case of emergency? _____ Phone Number _____

Who may we thank for referring you to our office? _____

II. RESPONSIBLE PARTY INFORMATION (If different than above)

Name _____ Relationship to patient _____

Last

First

Middle

Residence: Street _____ City _____ State/Zip _____

Mailing Address _____ City _____ State/Zip _____

If different than residence

Home Phone _____ Work Phone _____ Birthdate _____

III. INSURANCE INFORMATION

Does patient have dental insurance coverage? _____

PRIMARY INSURANCE

Subscriber's Name _____

Subscriber's Birthdate _____

Subscriber's Soc. Sec. # _____

Subscriber's Employer _____

Insurance Company _____

Insurance Co. Address _____

Group # _____ Local # _____

Does patient have dental insurance coverage? _____

SECONDARY COVERAGE

Subscriber's Name _____

Subscriber's Birthdate _____

Subscriber's Soc. Sec. # _____

Subscriber's Employer _____

Insurance Company _____

Insurance Co. Address _____

Group # _____ Local # _____

ASSIGNMENT & RELEASE: I authorize the dentist or insurance company to release any information required for payment or review of insurance claims. I hereby authorize my insurance benefits to be paid directly to Dr. Trason Shoquist DMD and I am financially responsible for any balance due, regardless of the amount my insurance chooses to pay, or in the event of nonpayment by my insurance company.

Signature (Parent if minor) _____ Date _____