**PATIENT INFORMATION**

3009 S. Mt. Vernon (Lincoln Heights), Spokane, WA 99223 • ph: 509.534.2666, fax: 509.534.1392

Date of appointment Time

**Patient information** *Thank you for completing this confidential information. We look forward to your visit.*

Name Married Single Male Female

Address

Street

Apt. No.

City

State Zip

Home phone Work phone Cell phone E-mail Address Birth date Employer Soc. Sec. No.

Yellow pages Advertisment Website Other

From a patient of our practice (name)

How did you hear about our office?

**Person responsible for account** *(if not same as above)*

Name

Married Single Male Female

Address

Street

Apt. No.

City

State Zip

Work phone Home phone Birth date

Employer Soc. Sec. No. Relationship to patient: Self Spouse Parent Other

# Insurance Information

(PRIMARY)

Dental Insurance Co.

Subscriber

Last First MI

Insurance Company Address

Street City State Zip

Insurance Company Phone Subscriber I.D. No. Subscriber Soc. Security No. Policy/Group No.

Relationship to patient:

Self Spouse Parent Other Secondary Insurance Yes No

# Person to contact outside of immediate family in case of emergency

Name Phone

Last First MI Home # Work #

Address

Street

Apt. No.

City

State Zip

# Authorization

**Insurance?**

**See Financial Options Sheet**

I hereby authorize payment directly to Dr. Hone of the group insurance benefits otherwise payable to me. I hereby authorize Dr. Hone to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are true and correct to the best of my knowledge.

Signature Adult patient

Parent/Guardian

Date