DENTAL ARTS CENTER

Jonathan E. Beaugez, D.M.D.
IMPLANTS.GENERAL.COSMETIC

PATIENT INFORMATION FORM

Today's Date:

We are a dedicated team who support our patient's pursuit for optimal health. Together we achieve this through education, trust, integrity, and open communication.

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name (to be called): _____ Gender: ☐M ☐F

Birth Date: _____ _____ _____ Age: _____ ☐Single ☐Married ☐Widowed

Social Security #: _____ _____ _____ Driver's License #: _____

Mailing Address: _____

_____

_____

Email Address: _____

May we email appointment reminders to you? ☐Yes ☐No

Best phone number to contact you:

Mobile: _____ Home: _____ Work: _____

Employer: _____ Employer Phone Number: _____

Employer Address: _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Guarantor of the account (Person responsible for payment, if different from above)

Name: _____ Relationship to Patient: _____

Phone Number: _____ Mailing Address: _____

Social Security #: _____ _____ _____ Birth Date: _____ _____ _____

Employer: _____Employer Phone Number: _____

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INSURANCE INFORMATION

Primary Insurance

Carrier/Insurance Company: _____

Group #: _____ Insurance #: _____

Subscriber ID/Policy Holder: _____

Subscriber ID/ SS #: _____ _____ _____ Date of Birth: _____ _____ _____

Subscriber Employer: _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to DR. JONATHAN E. BEAUGEZ of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____

Signature **Date**