Personal Information **Date** ________________

Last Name ________________________________First Name ______________________MI____
Name that I go by____
Referring Dentist or Person ___________________________Family Dentist_________________
What is your reason for coming here?____
SS# ___________________________ Male _____ Female ____ Birth date _______________
Address ____Age:________________
City _____________________________________ State _________________Zip Code __________
Home Phone ( )________________________Work Phone ( )__________________________
Best time to call ___________May we call you at work? _______Cell #____________________
E-Mail Address (please print clearly) ____
Employer _________________________________ Occupation______________________________
Employer's Address____

ARE YOU ELEGIBLE FOR MEDICARE PART B? YES _____ NO _____

Spouse (or other Responsible Party)

Last Name _____________________________First Name _____________________________MI___
Birth date ____________________Age_______SS#____
Employer____
Address of Employer ____
Address (if different from patient) ____

Primary Dental Insurance **(Please provide insurance card for us to photocopy)**

Name of Insured Person ___________________________________Relationship to Subscriber_________
Insurance Company ____________________________________Group #__________________________
Address ____Phone ( )_________________________

Secondary Dental Insurance **(Please provide insurance card for us to photocopy)**

Name of Insured Person ___________________________________Relationship to Subscriber_________
Insurance Company ____________________________________Group #__________________________
Address____ Phone ( ) _____________________

Medical Insurance **(Please provide insurance card for us to photocopy)**

Name of insured person ___________________________________Relationship to Subscriber_________
Insurance Company ____________________________________Group #__________________________
Address ____ Phone ( )____________________

Emergency Contact:

Name of person we could contact in emergency (not living with you)________________________
Relationship: ___________________________Phone #____________________________________

Preferred Method of Payment: **Cash _____Check _____MC _____Visa____ Disc_______**

Washington Driver's License Number ____

I understand that I am responsible for payment of all professional service on my behalf. I will pay any interest, reasonable lawyer fees or collection fees incurred regarding this account.
I hereby assign to Dr. Kim Larson any insurance payments or other rights under any applicable policy of insurance.
I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Kim E. Larson. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient (or responsible party)____

I have been given a copy of the Notice of Privacy Practices ___________________________________
(please sign if yes)