Northwest Periodontics

Stanley D. Halpern, D.D.S., P.C.

Patient's First Name: ______________________ Last Name: __________________________ Middle Initial: _______

Preferred Name: ___________________ Home Phone: ___________ Work Phone: __________ Cell Phone: ___________

Street Address: ____

City: _____________________________ State: _________ Zip Code: __________

Patient's Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date: _________________ Age: ___ Social Security: ________________ Driver License: ________________

E-Mail:__________________________________

Emergency Contact Person: ______________________ Emergency Contact Phone: ________________________

Referring Dentist/Physician/Person: ____

Is Patient the O Insurance Policy Holder O Responsible Party

Responsible Party (if someone other than the patient)

Patients Relationship to Responsible Party: O Self O Spouse O Child O Other

Responsible Party's First Name: _____________________ Last Name: ____________________ Middle Initial: _______

Responsible Party's Street Address: ____

City: _____________________________ State: _________ Zip Code: __________

O Responsible Party is also Policy Holder for Patient O Primary Insurance Policy Holder O Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ______________________ Patient's Relationship to Insured: O Self O Spouse O Child O Other

Insured Date of Birth: ____________________

Information found on Dental Insurance Card Employer: ______________________ Group Number: ______________

Insured Social Security or Member ID number: ___________________ Insurance Company: ________________________

Insurance Company Address: ____

City, State, and Zip Code: ____

Secondary Insurance Information

Name of Insured: ______________________ Patient's Relationship to Insured: O Self O Spouse O Child O Other

Insured Date of Birth: ____________________

Information found on Dental Insurance Card Employer:_____________________ Group Number: ______________

Insured Social Security or Member ID number: ___________________ Insurance Company: ________________________

Insurance Company Address: ____

City, State, and Zip Code: ____