DENALI FAMILY DENTAL CENTER
DAVID L. MAISEY
DENTISTRY

DENALI FAMILY DENTAL CENTER

PATIENT DATA SHEET

Date _____

First Name:_____ Last Name:_____
Date of Birth:_____ Social Security #: _____ - _____ - _____ Sex: Male_____ Female_____
Address:_____ City:_____ State:_____ Zip Code: _____
Home #_____ Cell#: _____ Work #:_____
Email Address: _____

Responsible Party (If different from above, such as parent or guardian if under age 18)

First Name:_____ Last Name:_____
Date of Birth:_____ Social Security #: _____ - _____ - _____ Sex: Male_____ Female_____
Address:_____ City:_____ State:_____ Zip Code: _____
Home #_____ Cell#: _____ Work #:_____
Email Address: _____

Primary Insurance

Policy Owner's Name:_____Policy Owner's Date of Birth:_____
Policy Owner's Social Security #: _____ - _____ - _____
Employer:_____Employer Address:_____
Insurance company:_____ID#:_____Group#:_____

Secondary Insurance

Policy Owner's Name:_____Policy Owner's Date of Birth:_____
Policy Owner's Social Security #: _____ - _____ - _____
Employer:_____Employer Address:_____
Insurance company:_____ID#:_____Group#:_____

As a courtesy to our patients, we will submit your insurance for you. It is important that you realize that we are not your insurance company. If you have difficulty or frustration with the speed of payment or the amount of payment by your carrier, please direct that frustration to the insurance company.

Signature Filer:

1. I realize that I am personally responsible for the payment on all services rendered on my behalf or on the behalf of my dependent family members. (Signature)_____
2. I authorize the release of any information relating to insurance claims.
   (Signature)_____
3. I hereby authorize payment directly to the treating dentist, Dr. Maisey, for group benefits otherwise payable to me.
   (Signature)_____

Who may we thank for referring you to us?

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