Edward H. Segal, D.D.S., Ltd.

Excellence in Periodontics • Implants • Oral Medicine

Welcome to our office! Our goal is to provide you with excellent care in a gentle caring atmosphere.

Please fill out the information below so we can get to know you. If you have any questions at any time please do not hesitate to ask any of us.

PATIENT INFORMATION

Date: _____

Name: _____ Soc.Sec.No. _____
Last First Initial

Birth date: _____ Driver's License. No: _____
Month / Day / Year

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____ E-mail: _____

Business Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Whom may we thank for referring you to our office? _____

Person to contact in case of an emergency? _____
Name Telephone

DENTAL INSURANCE

	Primary	Secondary
Company Name:		
Insured Name:		
Relation to Patient:		
SSN of Insured:		
DOB of Insured:		
Insurance Company:		
ID / Group Number:		

I understand that this office abides by the HIPPA policies posted in the waiting room. I herby authorize payment directly to the dental office for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid for by insurance, and for all services rendered on my behalf or my dependents. The information on this page and the medical history are correct to the best of my knowledge. I understand that if my account would need to be placed in collections, I will be responsible for the account balance as well as any and all associated collection, attorney, and court fees.