PATIENT HISTORY

Christina Wroblewski, D.D.S. 3814 Fairview Drive Anderson, IN 46013

PATIENT NAME_____ Age_____
LAST FIRST MIDDLE

Social Security Number_____ Date Of Birth_____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed (Check One) Home Phone_____

Address_____ City_____ State_____ Zip_____

EMAIL_____ How would you like to be contacted?
___email ___text ___home ___cell

Employed By_____

Employer's Address _____ Phone_____

Spouse's Name_____ Date of Birth _____

Spouse's Employer & Address_____ Phone _____

Name Of Emergency Contact_____ Phone_____ Relation_____

Nearest Relative Not Living With You_____ Phone_____ Relation_____

PLEASE COMPLETE FOR PARENT OF MINOR CHILDREN OF STUDENTS WITH A DIFFERENT BILLING ADDRESS

FATHER'S NAME STREET CITY STATE ZIP

HOME PHONE WORK PHONE EMPLOYER EMPLOYER'S ADDRESS

MOTHER'S NAME STREET CITY STATE ZIP

HOME PHONE WORK PHONE EMPLOYER EMPLOYER'S ADDRESS

DO YOU HAVE ANY DENTAL INSURANCE? ❑ YES ❑ NO

PRIMARY INSURANCE COMPANY

ADDRESS

INSURED'S NAME POLICY# S. SECURITY#

DENTAL INSURANCE INFORMATION

SECONDARY INSURANCE

ADDRESS

INSURED'S NAME POLICY# S. SECURITY#

I HEREBY AUTHORIZE TREATMENT FOR THE PATIENT LISTED ABOVE. I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND REQUEST THAT PAYMENT UNDER THE DENTAL INSURANCE PROGRAM BE MADE PAYABLE TO DR. CHRISTINA WROBLEWSKI ON ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. THERE WILL BE AN INTEREST CHARGE OF 1-1/2 % ON BALANCES NOT PAID IN FULL AT TIME OF SERVICES RENDERED. IF FOR ANY REASON THAT ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION AND LEGAL FEES.

I UNDERSTAND THAT IF THE WORKER'S COMP CARRIER AND THE EMPLOYER DO NOT PAY ON THIS CLAIM, I AM RESPONSIBLE TO PAY FOR SERVICES RENDERED. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

I AGREE THAT ALL THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S NAME

PATIENT'S SIGNATURE(IF MINOR , PARENT OR GUARDIAN) DATE