Jacob J Ridl D.D.S.

Patient's Name Last	First	Middle			Date of Birth	Sex
Patient's Address Street	Apt.#	City	State	Zip		Home Phone
Email		Cell Phone			SSN	
Person Responsible For Account Last	First	Middle				
Address Street	Apt.#	City	State	Zip		Home Phone
Marital Status M ❑ S ❑ D ❑ W ❑	Employer				Occupation	
Work Address Street	City	State	Zip			Work Phone
Spouse Name Last	First	Middle		Spouse Employer		Occupation
Work Address Street	City	State	Zip			Work Phone
Emergency Person We Can Contact (Other Than Your Family Home) Name	Work Phone	Home Phone				
Whom Can We Thank For Referring You To Our Office?						

INSURANCE INFORMATION

Insurance Coverage Yes ❑ No ❑	Insurance Company Name	Insurance Address		
Subscriber's Name	Patient's Relationship To Subscriber Self ❑ Spouse ❑ Dependent ❑		Subscriber's DOB	Subscriber's SSN
Group/Program Number	Employer	Employer Address		
Secondary Coverage Yes ❑ No ❑	Insurance Company Name	Insurance Address		
Subscriber's Name	Patient's Relationship To Subscriber Self ❑ Spouse ❑ Dependent ❑		Subscriber's DOB	Subscriber's SSN
Group/Program Number	Employer	Employer Address		

Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credits terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date_____