NEW PATIENT INTAKE FORM

Patient Information:

Name: _____ Age: _____ Date: _____
Address: _____
City, State, Zip: _____
Phone No.: (____)_____ Date Of Birth _____
Soc. Sec. No.: _____ Male___ Female___ Ht:____ Wt:____

Emergency contact:

Name: _____
Phone No.: (____)_____ Relationship: _____

Employer Information: (Your Employer At The Time You Were Injured)

Name of Business: _____
Address: _____
City, State, Zip: _____
Phone No.: (____)_____ Fax No.: (____) _____

Workers' Compensation Insurance Carrier Information:

Name: _____
Address: _____
City, State, Zip: _____
Phone No.: (____)_____ Fax No.: (____) _____
Claims Representative: _____
Claim No.: _____

Attorney Information: ( ) Check If None

Name: _____
Address: _____
City, State, Zip: _____
Phone No.: (____)_____ Fax No.: (____) _____

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The questions contained in these forms have been answered accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Meir Keller to release my information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Meir Keller insurance benefits otherwise payable to me.

Signature _____ Date: _____

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