Peter Drob, D.M.D, P.C

PATIENT INFORMATION

Name: _____ Birthday: M____D____Y_____ Sex: M or F
Street: _____ City: _____ State: _____ Zip Code: _____
Home #: (____) _____ - _____ Work #: (____) _____ - _____ Cell #: (____) _____ - _____
Marital Status: M S D Sep W SS #: _____ Former Patient? Y or N Physician: _____
Dentist(s): _____ Referring Doctor: _____ Other Referral: _____
Employer: _____ Occupation: _____ Address: _____
If Student: School: _____ Grade: ____ Full Time: ___ Part Time: ___ If College: Major: _____

BILLING INFORMATION

Responsible Party: _____ Address: _____
Home #: _____ Work #: _____ Cell #: _____ Relation to Patient: _____
Employer: _____ Work Address: _____ Occupation: _____

Mother/Guardian: _____ Address: _____
Home #: _____ Work #: _____ Cell #: _____ Occupation: _____
Employer: _____ Work Address: _____

Father/Guardian: _____ Address: _____
Home #: _____ Work #: _____ Cell #: _____ Occupation: _____
Employer: _____ Work Address: _____

INSURANCE INFORMATION

Dental Insurance Co: _____ Subscriber #: _____ Group #: _____
Subscriber Name: _____ Patient's Relation to Subscriber: Self___ Spouse___ Child___ Other___
Address: _____ SS#: _____Birthday: M____D____Y_____ Occupation: _____
Employer: _____ Address: _____ Work Phone: _____
Office Use Only Eff: _____ I: _____ II: _____ Max: _____ Avail: _____Ded: _____ Met: Y or N Initials: _____
PPO Plan: Y or N Out of Network Benefits: Y or N Covers GA: Y or N Limitations for GA: _____
If DDP, is it an MPE Plan? _____Yes _____No What type of plan? _____Open _____Closed

Dental Insurance Co: _____ Subscriber #: _____ Group #: _____
Subscriber Name: _____ Patient's Relation to Subscriber: Self___ Spouse___ Child___ Other___
Address: _____ SS#: _____Birthday: M____D____Y_____ Occupation: _____
Employer: _____ Address: _____ Work Phone: _____
Office Use Only Eff: _____ I: _____ II: _____ Max: _____ Avail: _____Ded: _____ Met: Y or N Initials: _____
PPO Plan: Y or N Out of Network Benefits: Y or N Covers GA: Y or N Limitations for GA: _____

Medical Insurance Co: _____ Subscriber #: _____ Group #: _____
Subscriber Name: _____ Patient's Relation to Subscriber: Self___ Spouse___ Child___ Other___
Address: _____ SS#: _____Birthday: M____D____Y_____ Occupation: _____
Employer: _____ Address: _____ Work Phone: _____
Office Use Only Eff: _____ Copay: _____ Oral Benfits: Y or N Covers: Con Pan B PB ST N202 G/sed
PPO Plan: Y or N Out of Network Benefits: Y or N
Referral: Y or N Referral #: _____ Deductible: _____ % of Coverage: _____ Initials: _____

Medical Insurance Co: _____ Subscriber #: _____ Group #: _____
Subscriber Name: _____ Patient's Relation to Subscriber: Self___ Spouse___ Child___ Other___
Address: _____ SS#: _____Birthday: M____D____Y_____ Occupation: _____
Employer: _____ Address: _____ Work Phone: _____
Office Use Only Eff: _____ Copay: _____ Oral Benfits: Y or N Covers: Con Pan B PB ST N202 G/sed
PPO Plan: Y or N Out of Network Benefits: Y or N
Referral: Y or N Referral #: _____ Deductible: _____ % of Coverage: _____ Initials: _____

INSURANCE RELEASE INFORMATION

I authorize release of any information relating to this claim. I hereby authorize payment directly to Dr. Peter Drob of the group insurance benefits otherwise payable to me. However, if the payment is paid to me, I agree to forward payment to Dr. Peter Drob. I understand that I am responsible for all coasts of dental treatment.

_____

Signature **Date**