PATIENT'S INFORMATION

CHART NUM.

1. PATIENT'S FIRST NAME:	2. M.I.:	3. LAST NAME:	4. HOME PHONE:
5. STREET ADDRESS:	6. CITY, STATE, ZIP CODE		7. WORK PHONE:
8. E-MAIL:	9. BIRTH DATE:	10. SEX: M F	11. SINGLE MARRIED DIVORCED WIDOWED
12. SOCIAL SECURITY NUM:	13. DRIVER'S LIC. NUMBER:		
14. EMPLOYER:	15. EMPLOYER'S ADDRESS:		16. EMPLOYER'S FAX:
17. PRESENT POSITION:	18. SPOUSE'S NAME:		19. SPOUSE'S EMPLOYER:

20. IN CASE OF EMERGENCY, CONTACT (Specify someone that does not live in your household)

21. WHOM MAY WE THANK FOR REFERRING YOU: Name:_____
Address: _____

22. WHO IS RESPONSIBLE FOR THIS ACCOUNT: (Whose name is to appear on billing statements?)
SELF SPOUSE PARENT OR GUARDIAN OTHER (If you checked "SELF" please skip the next section and continue with number 37)

RESPONSIBLE PARTY (if not the patient)

23. FIRST NAME:	24. M.I:	25. LAST NAME:	26. HOME PHONE:
27. STREET ADDRESS:	28. CITY, STATE, ZIP CODE:		29. WORK PHONE:
30. SOCIAL SECURITY NUM:	31. BIRTH DATE:		32. DRIVER'S LIC. NUMBER:
33. EMPLOYER:	34. EMPLOYER'S ADDRESS:		35. PRESENT POSITION:
36: E-MAIL:			

FOR PATIENTS WITH DENTAL INSURANCE

37. SUBSCRIBER'S FIRST NAME:	38. M.I.:	39. LAST NAME:	40. HOME PHONE:
41. STREET ADDRESS:	42. CITY, STATE, ZIP CODE:		43. BIRTH DATE:
44. EMPLOYER:	45. EMPLOYER'S ADDRESS:		46. INSURANCE CO.:
47. CONTRACT NUM. OR S.S. NUM.:	48. PLAN NAME:		49. GROUP NUM.:

50. PATIENT' RELATION WITH SUBSCRIBER:	51. ARE YOU ELIGIBLE FOR ADDITIONAL DENTAL INSURANCE ?: NO
SELF SPOUSE CHILD	YES, NAME OF THE SUBSCRIBER: _____
OTHER	INSURANCE: _____
	PLAN NAME: _____ CONTRACT NUM: _____

ASSIGNMENT AND RELEASE (Does not apply to discount plans)

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Jorge Munoz, D.M.D., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance claims.

RESPONSIBLE PARTY SIGNATURE	RELATIONSHIP WITH PATIENT	DATE

PLEASE COMPLETE HEALTH HISTORY ON THE OTHER SIDE ►