PATIENT INFORMATION - DRS KORB & MERAT
CONFIDENTIAL

Name of Patient ______________________ M / F Date of birth ______________

Address ______________________ City ____________ State ________ Zip ____________

Cell Phone ______________ Home Phone ______________ Work Phone ______________

Social Security # ______________________ Email ______________________

What is your confirmation preference?

Home tel. # ________ ☐
Cell phone ________ ☐
Text ________ ☐
Work # ________ ☐
E-mail ________ ☐

PERSON FINANCIALLY RESPONSIBLE

Name ______________________ Work # ____________
Relationship to Patient ______________________
Social Security # ______________________
Birth Date ______________________
Employer ______________________
Address ______________________

SPOUSE / PARENT

Name ______________________ Work # ____________
Relationship to Patient ______________________
Social Security # ______________________
Birth Date ______________________
Employer ______________________
Address ______________________

DENTAL INSURANCE INFORMATION

Prime Carrier: ______________________
Address: ______________________
Group # ______________________
Covered Employee: ______________ DOB ________

Secondary Carrier: ______________________
Address: ______________________
Group # ______________________
Covered Employee: ______________ DOB ________

RELATED INFORMATION: Please Complete

PHARMACY PREFERENCE: ______________ Kaiser ID# (if applicable) ______________
(Name) (phone #)

IN CASE OF EMERGENCY CONTACT: ______________________
(Name) (phone #)

WHOM MAY WE THANK FOR REFERRING YOU: ______________________
(Name) (phone #)

ACKNOWLEDGMENT AND AUTHORITY

Consent is hereby given for treatment as necessary and desirable for the above listed patient, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending dentist, or his dental assistant, or qualified designate.

I accept full responsibility for payment of my account and realize fees are due, in full, AT THE TIME OF SERVICE, unless other arrangements are made, in writing, before service is provided. I agree to pay a finance charge of 1 1/2% per month on any balance not cleared within 60 days of service. I realize any insurance estimate quoted to me by this office are only estimates determined from my policy, and do not represent actual insurance payments. I further realize that appointments made by me are commitments and the time is reserved just for me. If I cannot keep my commitment ***I will give 2 working days notice (closed Friday) to change my appointment*** **and understand if required notice is not given a cancellation fee will be charged.**

______________________ X ______________________
Today's Date Patient or Guardian Signature

POS® Reorder # 1016137