David Garlock DMD MS PC
Orthodontic Specialist

garlockORTHODONTICS

PATIENT INFORMATION

Patient's Name_____Nickname_____Sex_____

Date of Birth_____

Home Address_____

City, State, Zip_____ Home Phone_____

General DDS_____ Email_____

Referred By_____

Information for patients who are minors:

FATHER	MOTHER
Name_____	Name_____
Address_____	Address_____
_____	_____
Work Phone_____	Work Phone_____
Cell Phone_____	Cell Phone_____
SS#_____DOB_____	SS#_____DOB_____
Drivers License #/State _____	Drivers License #/State _____

Parent's Marital Status: Married____ Separated ____Divorced ____Widowed____ Single____

Insurance Information (Please fill out highlighted portion to verify eligibility):

Primary Insured Name_____ Date of Birth ____/____/_____

Employer _____ Name of Insurance Company _____

Member ID or SSN _____ Group Number _____

Signed _____ Date _____

Insurance Release (if applicable)

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____

Authorized Signature of Covered Person/Employee Date