EAU CLAIRE PERIODONTICS
3902 Oakwood Hills Pkwy, Suite 2
Eau Claire, WI 54701

Patient Information

Date: _____

Patient Name: _____(_____)
Title First MI Last Preferred Name

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other _____

Date of Birth: _____ Social Security #: _____-_____-_____
mm/dd/yyyy

Phone: _____/_____/_____/_____
Home Mobile Work Ext

Address: _____
City State Zip Code

Email: _____

If Applicable, ***Spouse's Name*** _____

If Dependent, **Mother's Name**_____ **Father's Name**_____

Who is your Referring Dentist/Doctor? _____

Who is your General Dentist? _____

Employment Information, If Applicable

Employer Name: _____ Phone: _____

Occupation: _____

Responsible Party Information

Name: _____(_____)
Title First MI Last Preferred Name

Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth: _____ Social Security #: _____-_____-_____
mm/dd/yyyy

Phone: _____/_____/_____/_____
Home Mobile Work Ext

Address: _____
City State Zip Code

Email: _____

Relationship to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Employment Information

Employer Name: _____ Phone: _____

Occupation: _____

FAMILY SHARED INFORMATION

I hereby consent that my dental/health care information may be shared both verbally and by mail with the following invidiuals
(leave blank if you do not want to share any information):

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship_____
_

Signature:_____Date:_____

INSURANCE INFORMATION

DENTAL

PRIMARY DENTAL
Policyholder Name: _____
Policyholder Birthdate: _____
Employer Name: _____
Name of Insurance Co: _____
Member ID or SS#: _____
Insurance Group #: _____

SECONDARY DENTAL
Policyholder Name: _____
Policyholder Birthdate: _____
Employer Name: _____
Name of Insurance Co: _____
Member ID or SS#: _____
Insurance Group #: _____

MEDICAL

PRIMARY MEDICAL
Policyholder Name: _____
Policyholder Birthdate: _____
Employer Name: _____
Name of Insurance Co: _____
Member ID or SS#: _____
Insurance Group #: _____

SECONDARY MEDICAL
Policyholder Name: _____
Policyholder Birthdate: _____
Employer Name: _____
Name of Insurance Co: _____
Member ID or SS#: _____
Insurance Group #: _____

Please keep your insurance cards out so a copy can be made. Thank you.

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INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO EAU CLAIRE PERIODONTICS, L.L.C. OF THE DENTAL/MEDICAL BENEFITS OTHERWISE PAYABLE TO ME.

Eau Claire Periodontics, L.L.C. is authorized to provide any insurance company(s) and consulting health care professionals information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

X_____
Patient or authorized person's signature Date