Douglas J Alterman
DMD PA

PATIENT INFORMATION FORM

Last Name _____ First _____ Middle _____ Mr. / Mrs. / Miss / Dr.

Street _____ Apt. # _____ City _____ State _____ Zip Code _____

Preferred Name _____ E-Mail Address _____

SS #: _____ - ___ - _____ DOB: ___ / ___ / _____

(_____) - _____ - _____ Home Phone
(_____) - _____ - _____ Work Phone
(_____) - _____ - _____ Cell Phone

Sex: M / F Marital: S / M / D / W Spouse Name: _____

Referring Doctor: _____ Referring Patient: _____

Employer: _____ Position: _____

Student: Full Time / Part Time School: _____

Primary Dental Insurance Coverage

Subscriber Name: _____ Relation to Patient: _____

Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / _____ SS #: _____ - _____ - _____

Employer: _____ Address: _____

Plan Name: _____ Group #: _____

Insurance Company: Address:

*Additional Dental Insurance Coverage

Subscriber Name: _____ Relation to Patient: _____

Address: _____ City: _____ St: _____ Zip: _____

DOB: _____ / _____ / _____ SS #: _____ -_____ - _____

Employer: _____ Address: _____

Plan Name: _____ Group #: _____

Insurance Company: Address:

Responsible Party

Last: _____ First: _____ Middle: _____

(_____) - _____ - _____ Home Phone
(_____) - _____ - _____ Work Phone
(_____) - _____ - _____ Cell Phone

I authorize and request my insurance company to pay directly to Dr. Alterman, DMD, PA; insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and may well have a different percentage of coverage than estimated or reject payment even against agreed predetermination. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____