Art Work Dental Dr. Brian Work, DMD

Blending technology & artistry to create beautiful smiles.

Patient Information

(Please Print)

Today's Date:

Patient Information					
Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Miss. ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street Address:			Birth Date: / /	Social Security #:	
PO Box:			Home Phone#: ( )		
City:	State:	Zip:	Other Phone#: ( )		
Occupation:	Employer:		Employer Phone #: ( )		
How did you hear about our office?			Email Address:		
Party Responsible for Account's Information					
Last Name:	First:	Middle:	❑ Mr. ❑ Miss. ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Relation to Patient:			Birth Date: / /	Social Security #:	
Street Address:			Home Phone#: ( )		
City:	State:	Zip:	Other Phone#: ( )		
Mailing Address (if different):		City:	State:	Zip:	
Occupation:	Employer:		Employer Phone #: ( )		
Spouse's Last Name:	First:	Middle:	Birth Date: / /	Social Security #:	
Occupation:	Employer:		Employer Phone #: ( )		
Primary Insurance					
Insurance Company:	Subscribers Name:		Subscriber's ID#:		
Insurance Company Street Address:			Phone #: ( )		
City:	State:	Zip:	Group #:		
Secondary Insurance					
Insurance Company:	Subscribers Name:		Subscriber's ID#:		
Insurance Company Street Address:			Phone #: ( )		
City:	State:	Zip:	Group #:		
In Case of Emergency					
Name of nearest relative not living with you:			Phone #: ( )		

I hereby authorize the release of information regarding diagnosis or treatment rendered to my insurance company or companies. I hereby assign the reimbursement of benefits to the doctor. If it becomes necessary to effect collections of amount, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Signature (Guardian's signature if minor):