Richard C. Fugler, D.D.S., M.D.

PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: ____/____/____

Sex: _____ Age: _____ Date of Birth: ____/____/_____ Soc. Sec. #: _____

Height: _____ Weight: _____

Address: _____

City: _____State: _____ Zip: _____

Mailing Address if different from above: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-mail Address: _____ How do you prefer to be contacted? Check Below:

☐ Cell Phone (Text) ☐ Cell Phone (Call) ☐ Home Phone ☐ Work Phone ☐ E-Mail

Employer: _____ Phone #: _____

Spouse's Name: _____ Phone #: _____

Responsible Party Name: _____ Date of Birth: ____/____/_____

Soc. Sec. #: _____ Drivers License # _____Relationship to Insured: _____

Address: _____ City: _____

State: _____ Zip: _____ Responsible Party Phone #:_____

Emergency Contact Name: _____

Address: _____ Relationship to Patient: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Physician: _____ Referring Dentist: _____ Orthodontist: _____

Pharmacy Name: _____ Pharmacy Location: _____

Reason for Visit: _____

Family members who have been patients here: _____

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PATIENT INSURANCE INFORMATION

Primary Insurance

Name of Dental Insurance Plan: _____ Phone Number: _____

Policyholder's Name: _____ Relationship to patient: _____

Date of Birth: _____ Soc. Sec. #: _____

Name of Medical Insurance Plan: _____ Phone Number: _____

Policyholder's Name: _____ Relationship to patient: _____

Date of Birth: _____ Soc. Sec. #: _____

Secondary Insurance

Name of Dental Insurance Plan: _____ Phone Number: _____

Policyholder's Name: _____ Relationship to patient: _____

Date of Birth: _____ Soc. Sec. #: _____

Name of Medical Insurance Plan: _____ Phone Number: _____

Policyholder's Name: _____ Relationship to patient: _____

Date of Birth: _____ Soc. Sec. #: _____