Mark I. Degen, D.D.S., M.D.
Red Rock Oral and Maxillofacial Surgery Centre

Patient Information

NAME:_____ Preferred to be called:_____
LAST FIRST MI

ADDRESS:_____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

PHONE (HOME):_____ (WORK): _____ EXT: _____ (CELL):_____

EMERGENCY CONTACT NAME: _____ PHONE:_____

TREATING DENTIST:_____PHONE:_____

SOCIAL SECURITY #:_____BIRTH DATE:_____EMAIL ADDRESS:_____

EMPLOYER:_____ OCCUPATION:_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE/HOW DID YOU HEAR ABOUT US?_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?_____

I WILL BE PAYING TODAY BY ☐ CASH ☐ CHECK ☐ CREDIT CARD

CREDIT CARD TYPE ☐ VISA ☐ MC ☐ AMEX ☐ CARECREDIT CARD#_____EXP:_____

Primary Dental Insurance Policy Holder Information

NAME:_____
LAST FIRST MI

POLICY HOLDER BIRTH DATE_____SSN OR ID#_____GROUP#_____

POLICY HOLDERS ADDRESS_____
STREET CITY STATE ZIP CODE

POLICY HOLDERS EMPLOYER NAME:_____EMPLOYERS ADDRESS:_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

INSURANCE COMPANY NAME: _____ INS. COMPANY PHONE #_____

Secondary Dental Insurance Policy Holder Information

NAME:_____
LAST FIRST MI

POLICY HOLDER BIRTH DATE:_____SSN OR ID#:_____GROUP#:_____

POLICY HOLDERS ADDRESS_____
STREET CITY STATE ZIP CODE

POLICY HOLDERS EMPLOYER NAME:_____EMPLOYERS ADDRESS:_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

INS. COMPANY NAME: _____ INS. COMPANY PHONE #_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature/Parent or Legal Guardian if minor Date