MARK R. BAGBY, DDS

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PATIENT DEMOGRAPHIC INFORMATION AND FINANCIAL RELEASE

First Name: _____ **MI:** _____ **Last Name:** _____

Preferred Name (If Different): _____ **Date of Birth:** _____ **Age:** ____ **Gender: M F**

Marital Status: *Circle One:* Married Single Divorced Widowed **If Married – Spouse Name:** _____
If Minor, Name of Responsible Party: _____

Address (Street, Apt #): _____

Address (City, State, Zip): _____

Address Type: ☐ **Home** ☐ **Relative** ☐ **Other**

Phone: ☐ **(Home)** _____ ☐ **(Cell)** _____ ☐ **(Work)** _____
<Check Preferred Contact Number Above>

Email Address: _____ **SS#:** _____

Primary Language: _____ **Race:** _____ **Ethnicity:** ☐ **Hispanic/Latino OR** ☐ **Non-Hispanic/Latino**

Employed by: _____ **Occupation:** _____

Work Address: _____ **Referred by:** _____

<u>INSURANCE INFORMATION</u>:

<u>Primary</u> Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ **SS #:** _____

Relationship to Patient: _____ **Employer Name:** _____

<u>Secondary</u> Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____ **SS #:** _____

Relationship to Patient: _____ **Employer Name:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

I HAVE RECEIVED AND FILLED OUT THE COMPOUND AUTHORIZATION FORM: RELEASE OF INFORMATION: ☐

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL AND BILLING INFORMATION NECESSARY TO PROCESS PAYMENT FOR CLAIMS AND REQUEST BENEFITS TO BE MAILED DIRECTLY TO THE PROVIDER UNTIL I REVOKE SAID AUTHORIZATION IN WRITING. I UNDERSTAND THAT I (AND SPOUSE IF MARRIED, OR PARENT IF MINOR) ASSUME RESPONSIBILITY FOR PAYMENTS OF AMOUNTS DUE FOR SERVICES RENDERED AND ABOVE THE AMOUNT COVERED BY INSURANCE OR THE TOTAL AMOUNT, IF I DO NOT HAVE APPLICABLE INSURANCE COVERAGE. MY SIGNATURE BELOW GUARANTEES MY ASSUMPTION OF RESPONSIBILITY TO THE AMOUNT OWED PURSUANT TO THIS AGREEMENT.

Patient Signature: _____ Date: _____