LAKELAND FAMILY DENTAL

ERIC RUIZ, D.D.S.
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PATIENT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	
NAME YOU PREFER TO BE CALLED	PREFERRED TITLE MR( ) MRS( ) MS( ) DR( ) ATTY( ) JDG( ) FR( ) SR( ) REV( )		
ADDRESS	CITY	STATE	ZIP CODE
BIRTHDATE	AGE	MALE( )	FEMALE( )
MARRIED( ) SINGLE( ) DIVORCED( ) WIDOWED( )			
HOME PHONE	CELL PHONE	WHICH PHONE NUMBER DO YOU PREFER? HOME( ), CELL( ), BUSINESS( ), ANY( )	
EMAIL ADDRESS			
OCCUPATION	EMPLOYER	BUSINESS PHONE	MAY WE CALL YOU AT WORK YES( ) NO( )
IF STUDENT: NAME OF SCHOOL	GRADE	CELL PHONE	SOCIAL SECURITY NUMBER
IF CHILD: MOTHER'S NAME	MOTHER'S OCCUPATION	FATHER'S NAME	FATHER'S OCCUPATION

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT	RELATIONSHIP TO PATIENT		
RESPONSIBLE PARTY'S ADDRESS	CITY	STATE	ZIP CODE
RESPONSIBLE PARTY'S HOME PHONE	WORK PHONE	OCCUPATION	PLACE OF EMPLOYMENT
RESPONSIBLE PARTY'S BUSINESS ADDRESS	CITY	STATE	ZIP CODE

SPOUSE INFORMATION

SPOUSE FIRST NAME (IF APPLICABLE)	SPOUSE LAST NAME	
SPOUSE OCCUPATION	SPOUSE EMPLOYER	SPOUSE BUSINESS PHONE

GENERAL INFORMATION

REFERRED BY	WHICH DOCTOR DO YOU PREFER TO SEE?		
CONTACT PERSON IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE	BUSINESS/CELL PHONE

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
GROUP NUMBER	EFFECTIVE DATE			
POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE			
EMPLOYER	EMPLOYER'S ADDRESS			
POLICY HOLDER'S SOCIAL SECURITY NUMBER	FAMILY COVERAGE?	SINGLE COVERAGE?		

SECONDARY INSURANCE POLICY

ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
GROUP NUMBER	EFFECTIVE DATE			
POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE			
EMPLOYER	EMPLOYER'S ADDRESS			
POLICY HOLDER'S SOCIAL SECURITY NUMBER	FAMILY COVERAGE?	SINGLE COVERAGE?		

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I hereby assign all dental benefits to which I am entitled to Dr. Eric Ruiz, D.D.S., and/or Dr. Samantha Ruiz, D.D.S. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

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SIGNATURE DATE