BERKS PROSTHODONTICS
ADVANCED IMPLANT AND RESTORATIVE DENTISTRY

Patient Information

Last Name | First Name | MI

Address

City | State | Zip | DOB | Male/Female

Email | SSN

Home Phone | Work Phone

Mobile Phone | Marital Status : Married Single Divorced Widowed (circle)

How would you like to be contacted? Phone call Email Text message (circle)

Who should we thank for referring you to our office/How did you hear about us?

Responsible Party (if other than above)

Last Name | First name | MI

Relationship to Patient : Parent Spouse Legal Guardian (circle) Other:

Address (if different from above)

City | State | Zip | Email

Home Phone | Mobile Phone | Email address

Dental Insurance Information

Name of Policy Holder | Relationship to patient: self spouse child other

Policyholder SSN or Insurance ID# | Policyholder DOB

Insurance Company | Group#

Insurance Company Address

Group Name/Employer (If shown on card)

Consent to Treatment and Insurance Billing

I consent to dental treatment. Berks Prosthodontics may contact me via the above phone and electronic routes. I acknowledge that I am responsible for payment in full and authorize Berks Prosthodontics to bill insurance on my behalf.

Signature | Date