Confidential Patient Information

A B C

Patient's Name____
Last First Middle Int Nickname

Address____
Street City State Zip

Home Phone______________________ Birthdate______________________

Patient Resides with ______________________ Relationship to Child______________________

Confidential Responsible Party Information

Name____ Marital Status________
Last First Middle

Residence____ Own Rent
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address______ Home Ph______________ Work Ph______________ Cell__________

Previous Address (if less than 3 yrs.)____
Street City State Zip

Social Security #________________ Birthdate________________ Relationship to Patient______________

Employer______________________ Occupation______________ # Years Employed______________

E-mail Address for appointment reminders____

Spouse's Name____ Relationship to Patient______________
Last First Middle

Employer______________________ Occupation______________ # Years Employed______________

Social Security #____________ Birthdate______________ Work Phone______________ Cell#__________

Insurance Information

Policy Holder's Name______________________________ SS#______________ Birthdate____________

Policy Holder's Address____

Insurance Company______________________ Group No.__________ Union Local No.____________

Insurance Co. Address______________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Do you have double coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name______________________________ SS#______________ Birthdate____________

Policy Holder's Address____

Insurance Company______________________ Group No.__________ Union Local No.____________

Insurance Co. Address______________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone______________________ Relationship:______________________

I authorize my insurance benefits to be paid directly to Dr. Andrew J. Kapust. In addition, I authorize Dr. Andrew J. Kapust to release any information required for all insurance claims. I accept full financial responsibility for all charges not covered by insurance benefits. I also understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)______________________________ Date______________

CONFIDENTIAL (for record and pretreatment evaluation)

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