MAGNA DENTAL, PC
PATIENT BILLING INFORMATION

(REVISED 11-20-17)

PATIENT INFORMATION

PATIENTS LAST NAME:
PATIENTS FIRST NAME:
MIDDLE INITIAL:
PREFERRED:
DATE OF BIRTH:
SOCIAL SECURITY #:

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER
FAMILY STATUS: ☐ MARRIED ☐ SINGLE ☐ CHILD ☐ OTHER

HOME PHONE:
CELL PHONE:
WORK PHONE: EXT:
EMAIL ADDRESS:

HOME ADDRESS:
CITY:
STATE:
ZIP:

EMPLOYER:
EMPLOYER ADDRESS:
CITY:
STATE:
ZIP:

WHO REFERRED YOU TO US (SO WE CAN THANK THEM!):

☐ FRIEND NAME: _____
☐ RELATIVE NAME: _____
☐ PHONEBOOK
☐ OTHER EXPLAIN: _____

SPOUSE-OR-RESPONSIBLE PARTY-OR-POA INFORMATION

LAST NAME:
FIRST NAME:
MIDDLE INITIAL:

DATE OF BIRTH:
SOCIAL SECURITY #:
GENDER: ☐ MALE ☐ FEMALE ☐ OTHER
FAMILY STATUS: ☐ MARRIED ☐ SINGLE ☐ CHILD ☐ OTHER

HOME PHONE:
CELL PHONE:
WORK PHONE: EXT:
EMAIL ADDRESS:

HOME ADDRESS:
CITY:
STATE:
ZIP:

EMPLOYER NAME:
EMPLOYER ADDRESS:
CITY:
STATE:
ZIP:

INSURANCE INFORMATION

PATIENTS RELATIONSHIP TO INSURED: ☐SELF ☐ SPOUSE ☐ CHILD ☐OTHER

LAST NAME OF INSURED:
FIRST NAME OF INSURED:
MIDDLE INITIAL:

DATE OF BIRTH:
SOCIAL SECURITY #:

INSUREDS HOME ADDRESS:
CITY:
STATE:
ZIP:

INSUREDS EMPLOYER NAME:
ADDRESS:
CITY:
STATE:
ZIP:

INSURANCE PLAN NAME:
GROUP #:
ID #:
PAYOR ID #:
INSURANCE PHONE:
INSURANCE ADDRESS:
INSURANCE CITY:
INSURANCE STATE:
INSURANCE ZIP:

SECONDARY INSURANCE INFORMATION

PATIENTS RELATIONSHIP TO INSURED: ☐SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

LAST NAME OF INSURED:
FIRST NAME OF INSURED:
MIDDLE INITIAL:

DATE OF BIRTH:
SOCIAL SECURITY #:

INSUREDS ADDRESS:
CITY:
STATE:
ZIP:

INSUREDS EMPLOYER NAME:
ADDRESS:
CITY:
STATE:
ZIP:

INSURANCE PLAN NAME:
GROUP #:
ID #:
PAYOR ID #:
INSURANCE PHONE:
INSURANCE ADDRESS:
INSURANCE CITY:
INSURANCE STATE:
INSURANCE ZIP: