Welcome to Our Practice

Alan J. Robertson, DDS
320 West Main Street
Kutztown, PA 19530

Telephone (610) 683-9560

GENERAL INFORMATION

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Dr.,Mr.,Mrs.,Miss _____ _____ _____

Last First Middle Initial

Preferred Name _____ Sex _____ Date of Birth _____

Guardian's name, if patient is a minor _____

Cell Phone _____ Home Address _____

Street

_____ _____ _____ Home Phone _____

City State Zip Code

Occupation _____ Employer _____ No. of Yrs. _____

Business Addresss _____ _____ _____ _____

Street City Zip Code Telephone

Marital Status _____ Name of Spouse _____ No. of Dependents _____

Spouse's Occ. _____ Spouse's Employer _____ _____

Name of Employer Telephone

How did you learn about my office? _____ When? _____

Referred by _____

INSURANCE INFORMATION

Name of Dental Insurance Company _____ Group No. _____

Employee _____ Employee Social Security No. _____

Employee's Date of Birth _____ Employer _____

Employer's Address _____ _____ _____ _____

Street City Zip Code Telephone

Patient _____ Relationship to Employee _____

Has the patient had previous dental care under this plan? _____

THE PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

Name_____ Birthdate_____

Last First Middle Initial

Billing address_____

_____ _____ _____ _____

City State Zip Code

Home phone #_____ Work phone #_____

Cell phone #_____ SS #_____

Drivers License #_____ Relationship to patient_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am responsible for any balance not paid by my insurance company.

Signature_____