CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME_____ DATE OF BIRTH_____/_____/_____
Please Circle: Minor Single Married Divorced Separated Widowed

HOME ADDRESS _____CITY/TOWN_____STATE_____ZIP_____
HOME PHONE ( )_____-_____ MOBILE ( )_____-_____ WORK ( )_____-_____
E-MAIL _____SOCIAL SECURITY NUMBER_____
EMERGENCY CONTACT _____PHONE ( )_____/_____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP_____
HOME ADDRESS _____CITY/TOWN_____STATE_____ZIP_____
HOME PHONE ( )_____-_____ MOBILE ( ) _____-_____ WORK ( )_____-_____
SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____/_____/_____

DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP _____
DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY NUMBER _____
INSURED SUBSCRIBER NUMBER_____ GROUP NUMBER _____
NAME OF EMPLOYER_____PHONE ( )_____-_____
NAME OF INSURANCE COMPANY_____
ADDRESS_____CITY/TOWN_____STATE_____ZIP_____
INSURANCE COMPANY PHONE ( )_____/_____ FAX ( )_____-_____

ADDITIONAL DENTAL INSURANCE? YES_____NO_____If yes, please complete the following:
NAME OF POLICY HOLDER_____ RELATIONSHIP _____
DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY NUMBER_____
INSURANCE SUBSCRIBER NUMBER_____GROUP NUMBER_____
NAME OF EMPLOYER_____PHONE ( )_____-_____
NAME OF INSURANCE COMPANY_____
ADDRESS_____CITY/TOWN_____STATE_____ZIP_____
INSURANCE COMPANY PHONE ( ) _____/_____ FAX ( )_____-_____

I/(patient/parent/guarantor/guardian) NAME_____understand and acknowledge I am financially responsible for the dental insurance deductible, co-payments, and all dental fees NOT covered by the dental insurance plan associated with my dental care/treatment, and all services provided by the dental team of Dr Gerald M. Winkler. I am aware that if I do not have dental insurance, all services rendered are my financial responsibility.

Accounts 60 days past due will be handled by our Accounts Receivables Partner - **TekCollect**. I understand a collection fee will be assessed to my account and become my responsibility as well.

I hereby authorize any/all insurance payments to Dr. Gerald M. Winkler. I fully grant the right to the dentist and dental team members to release my dental/medical histories, X-rays, and any other information about my dental treatment to third party payor and/or other health professionals associated with my care by any method, including postal mail, fax, and electronic transfer.

PLEASE SIGN_____DATE_____/_____/_____

patient / parent / guarantor / guardian

CONFIDENTIAL PATIENT INFORMATION

PLEASE SIGN_____DATE_____/_____/_____

patient / parent / guarantor / guardian

Gerald M. Winkler, D.M.D., P.C. 4 Cabot Place, Suite 8, Stoughton, MA 02072 (781) 341-WINK (9465)