WELCOME TO OUR OFFICE

We appreciate your selection of our office for your dental health and esthetic needs!

Our mission is to provide you quality dental care, esthetics and education that will enhance your health and appearance for a lifetime. We aim to exceed your expectations with our care, service and results in a comfortable environment using current technology with proficiency. In addition to being a full-service dental office, we are proud to offer Botox injections (for both medical and cosmetic implications), fillers, the Opus Plasma for skin resurfacing, smoothing, and tightening, as well as T.E.D. treatment for hair thickening and regrowth.

Office Hours

Dental treatment hours are Tuesday through Thursday, 8am to 5pm, and Mondays and Fridays are by appointment only, and they are usually reserved for longer or more exclusive care, including root canal care and thin molar extraction with sedation. The office is closed for major holidays as well as times when our doctors and team are attending continuing education seminars to keep abreast of the latest technology so that we may better serve you. Dental specialty care is available in our office, with subcontracted providers, for your convenience.

Emergencies & Scheduling Policies

One of our doctors can be reached 24 hours a day for emergencies, simply call our office phone number and follow the directions. In return we ask for your agreement in providing us a full 48 business hours' notice if you need to reschedule an appointment. We respect your time, thank you for respecting ours. A charge will be made for broken/canceled appointments with less than 48 business hours' notice so that we can operate in the most cost-effective and high-quality way that benefits all our patients. **Appointments rescheduled less than 48 hours in advance and missed appointments are subject to a minimum $60/hour broken appointment fee.** Your card on file will be automatically run for any missed appointment.

Financial & Insurance Information

A deposit or insurance co-pay is required to schedule procedures with the doctor. We bill your insurance carrier for services performed on your behalf and accept payment from your carrier for those services. You are responsible for the **estimated** patient portion when scheduling and any residual due, if any, after insurance pays a claim. Your carrier communicates the same correspondence to us both. When a claim is paid, your card on file will be charged if there is a residual due and we will send an email with corresponding paperwork. As a courtesy to you, if your carrier denies a claim, we will appeal the decision one time. If your carrier denies our appeal, you will be responsible for the unpaid balance. Unpaid balances that are left unpaid in excess of 30 days are subject to a service fee. Accounts with an outstanding balance over 45 days will accrue 18% of the remaining balance. Any additional fees assessed to our office by outside companies (collection agency, attorney, etc.) will be added to your balance

Method for Resolving Discomfort: All parties desire a method for resolving misunderstandings, disputes, discomfort, if any should occur-privately, quickly, and economically and in a friendly, educational manner. We therefore agree to resolve these matters using the communication, negotiation, mediation, and arbitration procedures set forth in the latest edition of the Law Forms Integrity Agreement. You may receive a copy of this standard form and information about it from our office. Unless we hear from you to the contrary, we shall assume that you are familiar with the Law Forms Integrity Agreement or have taken the time to review and understand it.

I HAVE READ AND UNDERSTAND THE ABOVE "WELCOME TO OUR OFFICE".

_____ _____

Signature of Responsible Party Date

_____

Printed Name of Responsible Party

Smile ARIZONA
GENERAL, COSMETIC & IMPLANT DENTISTRY
7327 E. Thomas Rd. Scottsdale, AZ 85251 | smilearizonadentistry.com | (480) 994 - 5225

Date: _____ Whom may we thank for referring you to our office? _____

Patient Name (Last, First, Middle): _____

What You Prefer To Be Called: _____ ☐ M ☐ F ☐ Other

Birthdate: _____ Age: _____ SSN: _____
(required if we are filing insurance)

Address: _____ Apt/Suite #: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____ Employer: _____

Employer Address: _____ City: _____ Zip/Postal Code: _____

Occupation: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Do you have children? ☐ Yes ☐ No How Many? _____

In Event of an Emergency:

Who should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

M.D. Name: _____ M.D. Phone #: _____

List Medical Specialists you see, (please include phone numbers): _____

_____

_____

Nearest Friend or Relative NOT living with you

Name: _____ Phone #: _____

Person Ultimately Responsible for Account:

Name: _____ Relation: _____ SSN: _____

Address: _____ Apt/Suite #: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

(Please provide a copy of your driver's license)

Driver's License #: _____ State/Province: _____ Expiration: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I full understand I am solely responsible for any and all balances not paid by my insurance company within 45 days. _____ **Initials**

Primary Dental Insurance (if any):

Company Name: _____ Address: _____

Zip/Postal Code: _____ City: _____ State/Province: _____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____ DOB: _____

Insured's Employer: _____ Insured's ID #: _____

Secondary Dental Insurance (if any):

Company Name: _____ Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____ DOB: _____

Insured's Employer: _____ Insured's ID #: _____

Smile ARIZONA
GENERAL, COSMETIC & IMPLANT DENTISTRY

7327 E. Thomas Rd. Scottsdale, AZ 85251 | smilearizonadentistry.com | (480) 994 - 5225

Do you have or have you ever had any of the following diseases, medical conditions or procedures?

- ☐ Yes ☐ No **AIDS/ARC Aids Related Complex** Positive HIV Blood Test When? _____
- ☐ Yes ☐ No **Allergy to Anesthetics** What? _____
- ☐ Yes ☐ No **Allergy to Latex Rubber** Reaction? _____
- ☐ Yes ☐ No **Anemia**
- ☐ Yes ☐ No **Any Bleeding/Clotting or Other Blood Disorders** _____
- ☐ Yes ☐ No **Any Allergies (Note Below)**
- ☐ Yes ☐ No **Anorexia/Bulimia/Any Eating Disorder** What? _____
- ☐ Yes ☐ No **Arthritis/Rheumatism**
- ☐ Yes ☐ No **Asthma**
- ☐ Yes ☐ No **Back Problems** What? _____
- ☐ Yes ☐ No **Blood Transfusion** When? _____
- ☐ Yes ☐ No **Cancer/Tumors** Diagnosed _____
- ☐ Yes ☐ No **Radiation or Chemotherapy?** When? _____
- ☐ Yes ☐ No **Chemical/Alcohol Dependency** What? _____ Consumed/week: _____
- ☐ Yes ☐ No **Circulatory Problems**
- ☐ Yes ☐ No **Cosmetic Surgery** What? _____
- ☐ Yes ☐ No **Wear Contact Lenses**
- ☐ Yes ☐ No **Emphysema**
- ☐ Yes ☐ No **Depression treatment** What? _____
- ☐ Yes ☐ No **Diabetes reading** What? _____
- ☐ Yes ☐ No **Difficulty Breathing/Respiratory Problems**
- ☐ Yes ☐ No **Epilepsy/Seizures**
- ☐ Yes ☐ No **Fainting**
- ☐ Yes ☐ No **Frequent Fever**
- ☐ Yes ☐ No **Frequent Neck Pain**
- ☐ Yes ☐ No **Glaucoma**
- ☐ Yes ☐ No **Hay Fever**
- ☐ Yes ☐ No **Headaches** Frequency: _____ Severity: _____
- ☐ Yes ☐ No **Hearing loss/Aids**
- ☐ Yes ☐ No **Heart Problems**
- ☐ Yes ☐ No **Heart attack/Stroke** When? _____
- ☐ Yes ☐ No **Heart Surgery** When? _____
- ☐ Yes ☐ No **Heart Murmur** Diagnosed: _____
- ☐ Yes ☐ No **Rheumatic Fever, Scarlet Fever or Congenital Heart defect**
- ☐ Yes ☐ No **Angina/Chest Pains**
- ☐ Yes ☐ No **Artificial Heart Valve**
- ☐ Yes ☐ No **Mitral Valve Prolapse/Floppy Valve**
- ☐ Yes ☐ No **Pacemarker** Placed? _____
- ☐ Yes ☐ No **High Blood Pressure**
- ☐ Yes ☐ No **Low Blood Pressure**
- ☐ Yes ☐ No **Hepatitis Type**
- ☐ Yes ☐ No **Hypoglycemia**
- ☐ Yes ☐ No **Implants of any type** What? _____ Artificial Joints etc. _____
- ☐ Yes ☐ No **Jaw Problems - TMD/TMJ** ☐ Left ☐ Right ☐ Both
- ☐ Yes ☐ No **Kidney Disease**
- ☐ Yes ☐ No **Liver Disease**
- ☐ Yes ☐ No **Nervous Problems**
- ☐ Yes ☐ No **Night Sweats**
- ☐ Yes ☐ No **Recreational Drug Use** What? _____
- ☐ Yes ☐ No **Shingles** When? _____
- ☐ Yes ☐ No **Sinus problems**
- ☐ Yes ☐ No **Swollen Lymph Nodes** Location: _____
- ☐ Yes ☐ No **Thyroid Condition** What? _____
- ☐ Yes ☐ No **Tuberculosis/TB** When? _____
- ☐ Yes ☐ No **Ulcer/Stomach Problems**
- ☐ Yes ☐ No **Unexplained Weight Loss**
- ☐ Yes ☐ No **Have you had botox?**
- ☐ Yes ☐ No **Have you had dermal fillers?**
- ☐ Yes ☐ No **Have you had skin rejuvenation?**

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ Yes ☐ No How long? _____

Please indicate any of the following problems:

- ☐ Discomfort, Clicking, Popping, or Locking Jaw
- ☐ Red, Swollen, or Bleeding Gums
- ☐ Sensitive Tooth, Teeth, Gums, or Jaw
- ☐ Blisters or Sores in/around the Mouth
- ☐ Food Catching Between Teeth
- ☐ Lost/Broken Filling(s)
- ☐ Teeth Grinding/Clenching
- ☐ Ringing in Ear
- ☐ Broken/Chipped Teeth
- ☐ Swelling or Sore(s) in Mouth
- ☐ Stained Teeth
- ☐ Bad Breath
- ☐ Other (Please explain): _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't Know

Previous Dentist: _____ Phone #: _____ Last Dental Exam: _____

Last Dental X-Rays: _____ How often do you floss? _____ How often do you brush? _____

What type of toothbrush do you use? ☐ Manual (what kind): _____ ☐ Electric (what kind): _____

How would you rate your smile? ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Are you satisfied with your smile? ☐ Yes ☐ No

(Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Do you have dental anxiety? ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(None) 1 2 3 4 5 6 7 8 9 10 (High)

Have you ever had your teeth straightened? ☐ Yes ☐ No

Have you had an unfavorable reaction associated with dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you been satisfied with your previous dental care? ☐ Yes ☐ No

If no, please explain: _____

Would you like to keep your natural teeth? ☐ Yes ☐ No

Have you ever been treated for Periodontal Disease (Gum Disease)? ☐ Yes ☐ No

Has anyone in your family ever been treated for Periodontal Disease? ☐ Yes ☐ No

Do you have an removal partials or dentures? ☐ Yes ☐ No

Please list all medications you take, prescription and over the counter, include vitamins, herbals & supplements:

_____

_____

Are you taking any of the following medications?

- ☐ Nerve Pills
- ☐ Blood Thinners
- ☐ Pain Killers (including apirin)
- ☐ Tranquilizers
- ☐ Muscle Relaxers
- ☐ Insulin
- ☐ Stimulants
- ☐ Other(s): _____

Please list any other medical condition(s) you have ever had:

_____

Are you allergic to any of the following?

- ☐ Latex
- ☐ Apirin
- ☐ Penicillin/Amoxicillin
- ☐ Dental Anesthetics
- ☐ Tetracycline
- ☐ Other(s): _____

Do you use tobacco? ☐ Yes ☐ No

☐ How use? _____ ☐ How much? _____ ☐ How long? _____

Please rate your general health : ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

(Bad) 1 2 3 4 5 6 7 8 9 10 (Good)

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Antibiotics can make this pill ineffective for one month past month(s) of ingestion

Are you pregnant? ☐ Yes/How Long? ☐ No

Are you nursing? ☐ Yes ☐ No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires that patient portion is paid in full for all services rendered by the time of visit. If account is not paid in full within 45 days of the date of service, regardless of insurance status, you will be responsible for interest charges, collection agency fees and any other expenses or legal fees incurred in collecting your account.

- I give authorization to the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to aid in my treatment at any dental specialist to which I or the patient is referred.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.
- I give my permission to have my health discussed with my medical doctors of record and those that I have noted on this form.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. Details available at the front desk.

I HAVE READ AND UNDERSTAND THE ABOVE SECTION

☐ Adult Patient ☐ Parent or Guardian (print name): _____

Date: _____ Signature: _____

Please choose one that we may discuss your care with: ☐ Partner ☐ Parents ☐ Siblings

As part of our commitment to your overall health, we screen for oral cancer in our office.

We appreciate your cooperation in answering the questions on the attached page as part of our HPV oral cancer screening process.

HPV oral cancer is harder to discover than tobacco related cancers because the symptoms are not always obvious to the individual who is developing the disease, or to professionals that are looking for it. They can be very subtle and painless. A dentist should evaluate any symptoms that you are concerned with, and certainly anything that has persisted for two or more weeks.

Facts you should know about oral cancer:

- The age group most affected by HPV oral cancer is 25-50 year olds.
- HPV contributes to 40-80% of new oral cancer in the US.
- Early diagnosis equates to an 80-90% survival rate and is paramount in treatment success.
- 100 new cases of oral cancer are diagnosed every day.
- One American dies every hour from oral cancer.
- HPV cancer is deep within the tissues and further back in the mouth and throat therefore, we need your help in reporting symptoms.

What we now know about HPV oral cancer :

- There are 130 strains of HPV viruses, only a handful are oncogenic (cancer causing).
- HPV-16 causes cervical cancer and oral cancer. Men have a 3X greater ratio of HPV cancer over women.
- HPV virus is transmitted via skin to skin contact (transfer between epithelial cells) The HPV virus infects at least 50% of all people who have had sex at some time in their lives.
- Those that engage in sexual contact with 5 or more partners are at greatest risk. HPV is related to oral autoimmune conditions and periodontal disease.
- 7% of patients diagnosed with oral cancer have no identifiable cause (other risk factors have yet to be identified).

Smile ARIZONA
GENERAL, COSMETIC & IMPLANT DENTISTRY

To adequately screen for HPV-related oral cancer and rule out other conditions, we ask that you answer the following questions:

1. Have you experienced any swelling or pain in your face, mouth, neck, tonsils, or throat areas? ☐ Yes ☐ No
   If yes, please explain: _____
2. Do you have any painless, non-moving firm bumps on your neck? ☐ Yes ☐ No
   If yes, please explain: _____
3. Have you ever had a mouth sore that lasted more than two weeks? ☐ Yes ☐ No
   If yes, please explain: _____
4. Have you ever experienced any oral bleeding? ☐ Yes ☐ No
   If yes, please explain: _____
5. Have you recently noticed a change in the way things taste? ☐ Yes ☐ No
   If yes, please explain: _____
6. Have you recently noticed a change in the way your voice sounds? ☐ Yes ☐ No
   If yes, please explain: _____
7. Have you had any changes in the surface of your mouth? ☐ Yes ☐ No
   If yes, please explain: _____
8. Have you experienced any problems while eating or swallowing? ☐ Yes ☐ No
   If yes, please explain: _____
9. Have you recently had any changes to your weight? ☐ Yes ☐ No
   If yes, please explain: _____
10. Have you experienced any numbness or tingling in your face? ☐ Yes ☐ No
    If yes, please explain: _____
11. Have you had any recent changes in your vision? ☐ Yes ☐ No
    If yes, please explain: _____
12. Can you tell us about your vaccination history? ☐ Yes ☐ No

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GENERAL, COSMETIC & IMPLANT DENTISTRY

Weight (pounds): _____ Age (years): _____ Gender: ☐ Male ☐ Female

Height: _____ Neck Size (inches): _____ ID # (optional): _____

For Office Use Only

Tally ARES Risk Points

Neck Size
- +2 Male ≥ 16.5
- +2 Female ≥ 15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION - ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No

Co-morbidities +1 for each "Yes" response

Score ☐

Lung Disease	☐ Yes	☐ No	Nasal Oxygen Use	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No	Morning Headaches	☐ Yes	☐ No
Sleeping Medication	☐ Yes	☐ No	Pain Medication e.g. vicodin, oxycontin	☐ Yes	☐ No

Do NOT assign any points for these 8 responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = *Would Never Doze*
1 = *Slight Chance of Dozing*
2 = *Moderate Chance of Dozing*
3 = *High Chance of Dozing*

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place (theater, meeting, etc.)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Epworth Score

TOTAL the values from all 8 questions

- If 11 or less Score = 0
- If 12 or more Score = 2

Score ☐

On average in the past month, how often have you snored or been told that your snored?

☐ Never ☐ 0-1 times/week ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week

Do you wake up choking or gasping?

☐ Never ☐ 0-1 times/week ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

☐ Never ☐ 0-1 times/week ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week

Do you have problems keeping you legs still at night or need to move them to feel comfortable?

☐ Never ☐ 0-1 times/week ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week

Assign points for each of the first 3 responses

Score ☐

Score ☐

Score ☐

_____ Signature

_____ Phone Number

Total all 6 boxes from above:
- If points total = 4 or 5 (low risk)
- If points total = 6 to 10 (high risk)
- If points total = 11 or more (very high risk)

Point Total ☐

Smile ARIZONA BEAUTY
Beauty For Your Smile, Face & Skin

Skin Health Questionnaire: Cosmetic Medical Treatments

Please take a few moments to answer the questions below. We are pleased to offer non-surgical aesthetic procedures. Let us know if you would like more information on any of our newer services.

Please return to the front desk after completing.

Would you be interested in receiving facial rejuvenation treatments? ☐ Yes ☐ No

If "yes", which conditions are you interested in having treated? Select all that apply:

- ☐ Vertical Lip Lines
- ☐ Lines Around Mouth
- ☐ Age Spots
- ☐ Fine Lines/Wrinkles on Face
- ☐ Crow's Feet
- ☐ Enlarged Pores
- ☐ Other (Please Specify): _____
- ☐ Texture
- ☐ Tone
- ☐ Scars/Acne Scars
- ☐ Loss of Volume
- ☐ Neck Lines
- ☐ Neck Laxity
- ☐ Sagging Skin

Would you be interested in a FREE Cosmetic Consultation? ☐ Yes ☐ No

I would like updates for information on cosmetic procedures, products, and specials. ☐ Yes ☐ No

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Printed Name: _____ Cell Phone: _____

Signature: _____ Email: _____

Insurance Agreement

To our patients requesting that we file your insurance: please read and sign this form (responsible party) for us to accept payment directly from your insurance company.

1. Please remember that professional dental services are rendered and charged to you, the patient, not to an insurance company. You are responsible for the payment of all treatment fees on your account. If your insurance company fails to pay within **45 days**, you are agreeing to pay your account in full. We will continue to re-file paperwork, etc. on your behalf and always exhaust your options.

2. We will file but cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a claim. You are responsible for payment of your account.

3. Insurance deductibles and "co-payment" portions are due to schedule or as services are rendered.

4. Our office is willing but cannot make a totally accurate estimate of your insurance benefits to be paid since we do not have access to your insurance company records and insurance companies generally will only discuss exact fees with the people they insure. Many insurance companies pick and choose randomly what they will and will not cover. It is your sole responsibility to know the terms, agreements and amounts of coverage of your dental/medical insurance benefit contracts.

5. After each insurance claim is paid to our office by your carrier, we email or mail you a statement reflecting your current account balance. This statement shows any difference between the estimated coverage and the final amount your insurance company paid on your behalf. We respectfully request that you pay any difference promptly as indicated to keep your account balance paid in full. *This may generate more than one billing per month as we keep you informed regarding all action on your account.*

6. Thank you! We are happy to answer any inquiries regarding your account(s). And we will certainly make every effort to help you receive full value for any dental "insurance" you participate in. **We appreciate all your efforts in keeping your account current so we can focus our efforts on patient care.**

Our conscience and desire for your optimal health drives our treatment plans; not limitations or restrictions imposed by third parties.

_____ _____

Signature of Responsible Party Date

_____

Printed Name of Responsible Party

_____

Printed Name of Patient
(if different from Responsible Party)

Dr. Beth Vander Schaaf

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

Medical Insurance Information (NOT Dental Insurance)

Insurance Company: _____

ID #: _____ Group #: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: ( ) _____

Insurance Company Street Address: _____

City: _____ State/Province: _____

ZIP/Postal Code: _____ Country: _____

Secondary Medical Insurance Information (if applicable)

Insurance Company: _____

ID #: _____ Group #: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Patient: _____

Insurance Phone Number: ( ) _____

Insurance Company Street Address: _____

City: _____ State/Province: _____

Country: _____ ZIP/Postal Code: _____