Brian R. Fisher, D.D.S.

843 S. Garfield Avenue • Traverse City, MI 49686

PATIENT INFORMATION (CONFIDENTIAL - PLEASE PRINT)

Name: _____ Nickname: _____

Address: _____ City/State: _____ Zip: _____

Phone: (_____)_____ - _____ Cell Phone: (_____)_____ - _____

Sex: ❑ M ❑ F Birthdate: _____-_____-_____ Age: _____ Email: _____

What prompted you to choose Dr. Fisher as your dentist? _____ Social Security #: _____-_____-_____

_____ ❑ Married Spouse's Name _____

Employed? ❑ Yes ❑ No Student? ❑ Yes ❑ No ❑ Single ❑ Other _____

Employer: _____ Occupation: _____

Street: _____ City/State: _____ Zip: _____

Work Phone: (_____)_____ - _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

For minor child, who is responsible for bill (❑ Parent ❑ Guardian):

Last Name: _____ Name (First, Middle): _____

Address: _____ City/State: _____ Zip: _____

Phone: (_____)_____ - _____ Social Security #: _____-_____-_____ Birthdate: _____-_____-_____

Employer: _____ Work Phone: (_____)_____ - _____

INSURANCE

PRIMARY DENTAL INSURANCE INFORMATION			**FILL OUT ONLY IF YOU HAVE SECONDARY DENTAL INSURANCE**		
INSURED'S NAME			INSURED'S NAME		
DATE OF BIRTH	SOC. SEC. NO.		DATE OF BIRTH	SOC. SEC. NO.	
EMPLOYER'S NAME			EMPLOYER'S NAME		
CITY, STATE, ZIP			CITY, STATE, ZIP		
NAME OF INSURANCE COMPANY			NAME OF INSURANCE COMPANY		
STREET ADDRESS			STREET ADDRESS		
CITY, STATE, ZIP			CITY, STATE, ZIP		
GROUP NO.	WHAT PERCENTAGE WILL THIS INSURANCE COMPANY COVER? I II III		GROUP NO.	WHAT PERCENTAGE WILL THIS INSURANCE COMPANY COVER? I II III	
RENEWAL DATE	MAX	DED	RENEWAL DATE	MAX	DED
EMPLOYMENT STATUS ❑ RETIRED ❑ ACTIVE	PATIENT'S RELATIONSHIP TO EMPLOYEE ❑ SELF ❑ SPOUSE ❑ DEPENDENT		EMPLOYMENT STATUS ❑ RETIRED ❑ ACTIVE	PATIENT'S RELATIONSHIP TO EMPLOYEE ❑ SELF ❑ SPOUSE ❑ DEPENDENT	

ASSIGNMENT & RELEASE

I hereby give my permission to the office of Dr. Brian R. Fisher to administer treatment, and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of any dental conditions.

I authorize the release of all information necessary to process any claim. I authorize payment of benefits either to myself or Dr. Brian R. Fisher as agreed upon at the time of treatment for services rendered.

I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges not paid by insurance. I agree that in the event of default in the payment of any amount due, if placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Signature: _____ Date: _____/_____/_____

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