

Michael P. Logue, D.M.D., P.A.
Patient Information Worksheet

PATIENT INFORMATION

Name: _____
Address: _____ Apt: _____
_____ Zip code: _____
Home phone: _____
Date of Birth: _____ Age: _____
Sex: M___ F___
Name of Spouse or Parent: _____
Referred by: _____
Dentist: _____
Do you have a note or X-rays from your dentist:
Yes___ No___

S.S. #: _____
Marital Status: M___ S___ W___ D___
Driver's Lic.: _____
Cell phone: _____
Work Telephone: _____
Work Address: _____

Employed by: _____
Physician: _____
Emergency contact Name: _____
Emerg. Contact Phone #: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Address: _____

Relationship to Patient: _____
Hm. Telephone: _____

INSURANCE INFORMATION

Medical: _____
HMO: _____ PPO: _____
Dental: _____
HMO: _____ PPO: _____

FINANCIAL POLICY

Payment is expected at time of service. Payment may be in the form of cash, personal check, MasterCard, Visa, or Traveler's check. We will issue a Superbill that contains all pertinent codes necessary for you to make an insurance claim with your health/dental carrier. Our office will also comply with all requests from insurance companies for additional claim documentation, if needed. Delinquent accounts may incur finance charges.

FORM OF PAYMENT

Cash___ Check___ MC/Visa___ **"Payment is expected at time of service."**

Authorization to release medical information:

Michael P. Logue, D.M.D., P.A. is hereby authorized to release any medical or incidental information that may be necessary for medical care or processing insurance.

Legal-Responsible party:

If patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

Contract to pay medical services:

I agree to be personally and fully responsible for payment.

Responsible party's signature

Responsible party's printed name

Date

Acknowledgement of Receipt of Privacy Practices: _____ (initial)