CONFIDENTIAL PATIENT INFORMATION

For Alan W. Haussermann, D.D.S.

PERSONAL INFORMATION: (Circle one): ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Prof.

Name:_____ DOB:_____SS#:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home: _____ Work:_____ Cell:_____

Employer_____Occupation_____

☐ ☐
Sex: M or F Marital Status: ☐ Single, ☐ Married, ☐ Separated, ☐ Divorced or ☐ Widowed, ☐ Partnered

Spouse Name:_____

Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name:_____ Relationship: _____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home: _____ Work:_____ Cell:_____

DENTAL INSURANCE INFORMATION:

Primary Insurance Co: _____ Employer: _____

Insurance Co Address: _____

Employee: _____ DOB (of employee): _____

Relationship: _____

SS#/ID # (of employee): _____ Policy/Group #: _____

Secondary Insurance Co: _____ Employer: _____

Insurance Co Address: _____

Employee: _____ DOB (of employee): _____

Relationship: _____

SS#/ID # (of employee): _____ Policy/Group #: _____

I authorize Dr. Haussermann, or his designated staff, to release diagnosis and treatment records to appropriate insurance and medical/dental personnel. I also understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: _____ **DATE:** _____