

PAUL R. GIBBS, D.D.S., M.S.
PERIODONTICS
Patient Registration and Insurance Information

Patient _____ Age _____ Date of Birth: _____
Last First MI (Mr., Mrs., Ms, Miss)

___ Child ___ Single ___ Married ___ Widowed ___ Divorced

Patient's SS# _____ Cell # _____
Mailing Address _____ Home Telephone _____
City _____ State _____ Zip Code _____

Patient's Employer _____ Work Telephone _____
Patient's Occupation _____
Nearest Relative _____ Address _____

Primary Dental Insurance:

Employee Name: _____ SS#: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____

Phone Number of Insurance Company: () - _____
Employee Date of Birth: - - _____
Group Number: _____

Secondary Dental Insurance:

Employee Name: _____ SS#: _____
Employer: _____
Dental Insurance Name: _____
Insurance Address: _____

Phone Number of Insurance Company: () - _____
Employee Date of Birth: - - _____
Group Number: _____

Assignment of Benefits

I hereby authorize payment directly to the named provider of the group insurance benefits otherwise payable to me.

Signed _____
Date _____

Release of Information

I authorize the release of any information necessary to process the claim

Signed _____
Date _____