Donald G. Weikum, D.D.S. 185 N. Frost Dr. Saginaw, MI 48638

PATIENT INFORMATION

Patient Name ____________________ Birth date ____________________

Address ____________________ Home phone ____________________

City ____________________ State ____________________ Zip Code ____________________

Patient's marital status: ☐ married ☐ single ☐ divorced ☐ widowed

Patient's Employer ____________________ Soc Sec No ____________________

Work Address ____________________ Work phone ____________________

Dental Insurance Co. ____________________ Insurance phone ____________________

Spouse's Name ____________________ Birth date ____________________

Spouse's Soc Sec No ____________________ Spouse's employer ____________________

Spouse's work address ____________________ Work phone ____________________

Emergency contact ____________________ Phone ____________________

Patient's physician ____________________ Phone ____________________

Are you covered by spouse's dental insurance? ☐ Yes ☐ No If Yes, please complete information below.

Spouse's dental insurance ____________________ Insurance phone ____________________

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING SECTION

Mother's name ____________________ Father's name ____________________

Mother's address ____________________ Father's address ____________________

Mother's birth date____________________ Father's birth date ____________________

Mother's Soc Sec No ____________________ Father's Soc Sec No ____________________

Mother's employer ____________________ Father's employer ____________________

Mother's dental insurance ____________________ Father's dental insurance ____________________

Mother's insurance phone ____________________ Father's insurance phone ____________________

I HEREBY AUTHORIZE:

- Dr. Weikum to release to my insurance company any information acquired in the course of my treatment. This authorization also allows the release of any information to my physician or another dentist in the event it becomes necessary for me to be referred to another healthcare provider.
- my insurance company to pay directly to Dr. Weikum any dental insurance benefits I am due, relative to any services he has rendered on my behalf. Otherwise the services are payable by me. I understand that amounts deemed by my insurance company to be beyond what they consider "usual, customary, and/or reasonable charges" for said services will be paid by me. I also understand that I will be liable for any deduction and/or co-payment amounts indicated by my insurance company.
- Dr. Weikum and/or his staff to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.
- this agreement to remain in effect until revoked by me, in writing, and a copy given to Dr. Weikum.

I understand that the practice of dentistry is not an exact science. I understand NO GUARANTEES OR PROMISES will be made to me regarding the results of any dental treatment. I understand that I shall have the opportunity to discuss any procedures or treatments with Dr. Weikum or his staff participating in my care.

Signed ____________________ Date ____________________