

# Dr. Kopp & Associates

Where the Patient is Our Primary Concern

## PATIENT INFORMATION

DATE \_\_\_\_\_

PATIENT NAME MR. \_\_\_ MRS. \_\_\_ MS. \_\_\_ MISS \_\_\_ DR. \_\_\_ \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
Street city zip

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ PAGER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS (S\_\_\_) (M\_\_\_) (D\_\_\_) (W\_\_\_)

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER NAME / ADDRESS \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ x \_\_\_\_\_ May we call you at work? YES \_\_\_\_\_ NO \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

## INSURANCE INFORMATION

DENTAL INSURANCE? YES \_\_\_ NO \_\_\_ Insurance Company? \_\_\_\_\_

Policy Holders Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_  
Street city zip

S.S.# of policy holder \_\_\_\_\_ GROUP # \_\_\_\_\_

**\*\*\*YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. IT IS IMPOSSIBLE FOR US TO KNOW EVERY PATIENTS POLICY AS ALL OF THEM DIFFER. ANY CLAIM NOT COVERED FOR ANY REASON IS YOUR RESPONSIBILITY. (IE: MISSING TOOTH CLAUSE, WAITING PERIOD, NON COVERED PROCEDURE, IMPLANTS)**

Who may we thank for referring you? \_\_\_\_\_

REASON FOR CONSULTATION \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE