

William D. Payne D. M. D.

Patient Information Form

Patient Name: _____ Date of Birth: _____

Mailing Address: _____
Address City State Zip

E-mail address: _____

Home Phone: _____ Social Security #: _____

Marital Status: S M D W Other _____ Occupation: _____

Patient Employer: _____ Work Phone #: _____

Primary Care Physician: _____ Phone #: _____

Insurance Information

Primary Dental Insurance: _____ Phone #: _____

Subscriber's Name: _____ Patient's relationship to subscriber _____

ID#: _____ Group #: _____ Group Name _____

Secondary Dental Insurance: _____ Phone#: _____

Subscriber's Name: _____ Patient's relationship to subscriber: _____

ID#: _____ Group #: _____ Group Name _____

Person responsible for bill: _____ Home Phone #: _____

Mailing Address: _____ Social Security #: _____

Emergency Contact: _____ **Relationship to patient:** _____

Home phone #: _____ **Work phone #:** _____

The above information is true to the best of my knowledge. I hereby authorize [William D. Payne , D. M. D.](#) to release any medical or other information necessary to process my claims. I authorize my insurance benefits to be paid directly to [William D. Payne D. M. D.](#) for services rendered and understand that I am financially responsible for any charges not covered by my insurance carrier.

Signed: _____ **Date:** _____