

VILLAGE PLAZA DENTAL

4750 Village Plaza Loop #201 • Eugene, OR 97401
343-3822

PATIENT INFORMATION

DATE _____

PATIENT INFORMATION

<input type="checkbox"/> MR.	LAST NAME	FIRST	MIDDLE	AGE	DATE OF BIRTH	M	F	SOCIAL SECURITY #
<input type="checkbox"/> MRS.					/ /			- -
<input type="checkbox"/> MISS								

PERSON LEGALLY RESPONSIBLE

<input type="checkbox"/> MR.	LAST NAME	FIRST	MIDDLE	DATE OF BIRTH
<input type="checkbox"/> MRS.				
<input type="checkbox"/> MISS				

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
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EMPLOYED BY	OCCUPATION	SOCIAL SECURITY NUMBER
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BUSINESS ADDRESS	CITY	STATE	ZIP
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BUSINESS PHONE	EXT.	PAGER/CELL #	E-MAIL ADDRESS
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SPOUSE/PARTNER INFORMATION

NAME OF SPOUSE (LAST)	FIRST	MIDDLE	DATE OF BIRTH
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SPOUSE EMPLOYED BY	OCCUPATION	SOCIAL SECURITY NUMBER
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BUSINESS ADDRESS	CITY	STATE	ZIP
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BUSINESS PHONE	EXT	PAGER/CELL #	E-MAIL ADDRESS
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Name of nearest relative not living with you _____ Relationship to patient _____

Address _____ City _____ Zip _____ Phone (____) _____

Whom may we thank for referring you? _____

Do you have dental insurance? Yes No

Is there double coverage? Yes No

Primary Insurance Co. name & address

Secondary Insurance Co. name & address

Phone No.: _____

Phone No.: _____

Policy Holder: _____

Policy Holder: _____

Policy Holder Address: _____

Policy Holder Address: _____

Birth Date: _____

Birth Date: _____

SS # or ID #: _____

SS # or ID #: _____

Group #: _____

Group #: _____

Employer: _____

Employer: _____

Address: _____

Address: _____

I hereby authorize payment directly to Jay C. Lamb, D.M.D., P.C. Insurance Benefits _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature: _____

Date: _____