QUALITY DENTAL CARE
Bogdan N. Bodroug DDS, PS

Patient Information

Patient Name ______________________________ Birth date ___/___/_____ M or F
First M.I. Last (Circle)

Residence & Mailing Address ____
Street Po Box City State Zip

Employer ____________________ Occupation ________________

Address of the employer ______________________________

Driver's License No. ________________ State _____

Phone Numbers:
Home: ____________________
Cell: ____________________
Work: ______________ Ext: _____
Email: ____________________

Responsible Party Information

Please complete this section if someone other than patient will be paying the bill.

Responsible Person ______________________________ Birth date ___/___/_____ M or F
First M.I. Last (Circle)

Residence & Mailing Address ____
Street PO Box City State Zip

Relationship to Patient ____________________

Employer ____________________ Occupation ____________________

Phone Numbers:
Home: ____________________
Cell: ____________________
Work: ______________ Ext: _____
Email: ____________________

Dental Insurance Information

Primary Insurance ____________________ ___/___/_____ ____________ ____________
Name of the Policy Holder Birth date ID # Group #

Insurance Company ______________________________
Name of Insurance

______________________________ ____________
Address Phone number

Secondary Insurance ____________________ ___/___/_____ ____________ ____________
Name of the Policy Holder Birth date ID # Group #

Insurance Company ____________ ____________________ ____________
Name of Insurance Address Phone Number

Person to contact if unable to reach you directly

Name of friend or relative **(not living with you)** ______________________ ____________
First M.I. Last Relationship

Residence & Mailing Address ____
Street PO Box City State Zip

Phone number ____________________

How did you hear about our office?

- ☐ Magazine (indicate name) ____________________
- ☐ Web site
- ☐ Referral from different office/clinic
- ☐ Friend/relative

I certify that I am authorized to furnish the above information requested. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay to the dentist all benefits and authorize this signature on all insurance submissions.

Signature: ______________________________ **Date:** ____________________