DANIEL J. DERKSEN D.D.S. PLLC

NAME_____BIRTHDATE_____SS#_____

ADDRESS_____CITY_____STATE____ZIP_____

LAND LINE #_____CELL PHONE #_____

WORK #_____EMAIL _____

DRIVERS LICENSE NUMBER _____

IN CASE OF EMERGENCY, CONTACT_____#_____

HOW DID YOU HEAR ABOUT OUR OFFICE _____

FAMILY DOCTOR _____#_____

PREVIOUS DENTIST _____

CHECK APPROPRIATE BOX ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

INSURANCE INFORMATION

NAME OF INSURED _____ INSURED BIRTHDATE_____

NAME OF EMPLOYER _____INSURED SS#_____

NAME OF INSURANCE_____ GROUP # _____

ADDITIONAL INSURANCE

NAME OF INSURED _____ INSURED BIRTHDATE_____

NAME OF EMPLOYER _____INSURED SS#_____

NAME OF INSURANCE_____ GROUP # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage, listed above and assign directly to Daniel J. Derksen all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Person Signature _____Date_____