James J. Karam, D.D.S. **Excellence In Dentistry**

Personal And Insurance Information:

NAME _____ BIRTH DATE _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC. SEC. #_____ MARITAL STATUS _____

HOME PHONE _____ BUS. PHONE _____

OCCUPATION _____ EMPLOYER _____

FAMILY PHYSICIAN _____ NAME OF NEAREST RELATIVE _____

REFERRED BY _____ PHONE OF NEAREST RELATIVE _____

DENTAL INSURANCE _____ YES _____ NO _____ PREVIOUS DENTIST _____

If You Have Dental Insurance Complete The Following:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP #_____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

If You Have Any Additional Dental Insurance Complete The Following:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP #_____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The medical and dental questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the medical and dental history , diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and, or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient or parent if minor

FOR OFFICE USE ONLY

Deductible Amount _____

Yearly? Yes _____ No _____

Family Deductible _____

Ins. Effective Date _____

Renewal Date _____

Maximum _____

Class I _____

Class II _____

Class III _____

X-RAYS: Bitewings Class _____

Pa's Class _____

FMX Class _____

Last FMX ? _____ How Often ? _____

Prophy Covered How Often ? _____

Perio Prophy (04910) Yes _____ No _____

Crowns % _____

Sealants Yes _____ No _____