Karlstad & Roseau Dental Clinics

Ed Gracza DDS
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Patient Information

Date_____Patient Name_____

SS#_____Male_____Female_____Birthdate_____Cell Phone_____

Address_____Home Phone_____

City_____State_____Zip Code_____OK to text reminders to Cell? Yes_____No_____

E-Mail_____Single_____Married_____Divorced_____Widowed_____

Patient's or Parent's Name_____

Employer_____Work #_____

Person to contact in case of emergency_____Phone #_____

Name of the person, if any, who referred you to our office _____

Responsible Party

Name_____Relationship to patient_____

Address_____Cell #_____

Birthdate_____E-mail_____Home#_____

Employer_____Work#_____

Insurance Information

Name of insured_____Relationship to patient_____

Birthdate_____SS# or ID#_____Group #_____

Name of Employer_____City, State, Zip_____

If you have additional insurance, please complete the following:

Name of insured_____Relationship to patient_____

Birthdate_____SS# or ID #_____Group #_____

Name of Employer_____City, State, Zip_____

I authorize the release of any information concerning my (or my child's) health care, advice & treatment provided for the purpose of evaluation & administrating claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature_____Date_____