



PATIENT INFORMATION

Patient Name _____ Prefer to be addressed as _____
 Birthdate _____ Sex _____ Marital Status _____ SSN _____ Drivers Lisc: _____
 Home address _____
 City/State _____ Zip _____ Home phone _____
 Employer _____ Work phone _____ May we call you at work? _____
 Email address _____ Cell Phone _____
 Preferred method of contact: Home phone _____ Work phone _____ Email _____ Cell phone _____
 Student _____ Where? _____ Whom may we thank for this referral? _____
 Nearest relative not living with you _____ relationship _____ phone # _____

Guarantor (if not same as above) - Please note: we cannot bill a non-custodial parent
 Name _____ Relationship _____
 Birthdate _____ SSN # _____ Drivers License _____
 Billing Address _____
 City/State _____ Zip _____ Home phone# _____
 Employer _____ Work phone _____ May we call you at work? _____

Other Family Members			
Name	Relationship	Employer/School	Work phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Insurance	Primary	Secondary
Insurance Co. Name	_____	_____
Billing Address	_____	_____
Telephone	_____	_____
Group #	_____	_____
Policyholder's name	_____	_____
Policyholders SS #	_____	_____
Relationship to Patient	_____	_____
Policyholder's Birthdate	_____	_____
Policyholder's Employer	_____	_____

I hereby authorize Dr. Houlihan to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____

Policyholder Signature _____ Date _____

Timothy J. Houlihan Jr., D.M.D.