

Daniel E. Blickenstaff, DDS, PC  
975 NW Saltzman Road – Portland, Or. 97229  
Phone: 503-646-1463 Fax: 503-646-0753  
[doctordands@verizon.net](mailto:doctordands@verizon.net)

**GENERAL INFORMATION**

\_\_\_\_\_

<b>First</b>	<b>Middle</b>	<b>Last</b>
--------------	---------------	-------------

If patient is a minor, name of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_ Best way to contact you? \_\_\_\_\_

**Date of birth** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Drivers License #** \_\_\_\_\_

Sex: Male  Female  Marital Status: Single  Married  Divorced  Widowed

Name of spouse/partner \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Phone: H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

**DENTAL INSURANCE**

Name of insured: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of birth \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ADDITIONAL INSURANCE**

Name of insured: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of birth \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I certify that I, and/or my dependents, have insurance coverage with \_\_\_\_\_ and assign all insurance benefits directly to Daniel E. Blickenstaff, DDS. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

\_\_\_\_\_  
Signature of Patient, Parent or Personal Representative

\_\_\_\_\_  
Date

