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*****B f qe qtf cpf f u e qo

GENERAL INFORMATION

First	Middle	Last
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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

