AJEY VARMA D.D.S., P.L.L.C.

PRACTICE LIMITED TO PROSTHODONTICS

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Name _____ Social Security # _____
Last First Middle

Home address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Birth date _____

Employer _____ Address _____ Occupation

Spouse/Parent name _____ Phone _____ Social Security # _____ Birth date _____

Spouse employer _____ Address _____ Phone _____

In case of emergency:

Relative to contact other than spouse or parent _____ Phone _____

Another person to contact other than relative _____ Phone _____

Who may we thank for referring you to this office _____ Phone _____

Insurance information: If you have NO insurance, check here _____

Name of Insured _____ Social Security # _____ Birthdate _____

Name of Insurance Co. _____ Address _____

Policy Number _____ Group Number _____ Phone _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party _____ Address _____

Phone _____ Social Security # _____ Relationship to patient _____

Employer _____ Address _____ Phone _____

Reason for this visit: Illness _____ Injury _____ Job related injury _____ Auto accident _____

Date of injury or onset of problem ___/___/___ Major complaint _____

If your injury is job related, complete the following:

Name of person who can authorize treatment _____ Title _____

Company's insurance carrier _____ Phone _____ Ok'd by _____

Please sign and return to receptionist

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collection of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature _____ Date _____