

Kurt Buska, D.D.S.

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Patient Information

PERSONAL INFORMATION (Please print)

First Name: _____ MI: _____ Last Name: _____

Status (circle one): Single / Married / Widow / Child Sex: M / F

Date of Birth: _____ Patient SSN: _____

Mailing Address:

Street: _____ City: _____ State: _____ Zip: _____

Physical Address (if not the same):

Street: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Work: _____ Cell: _____

Would you like to be contacted by text? Y / N

Emergency Contact: _____ Phone: _____ Relationship: _____

PATIENT EMPLOYMENT INFO

Patient Employer: _____ Occupation: _____

INSURANCE INFORMATION

Do you have Dental Insurance? (circle) Yes / No

Subscriber Name, if not self: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____ Relationship to Subscriber : self / spouse / child / other

Subscriber Employer: _____ Employer Phone: _____

Insurance Company: _____

Insurance Group Number: _____ Insurance Phone: _____

Please present your insurance card to the receptionist

Who may we thank for referring you? _____

Dental Visit—Reason for today's visit: _____

What areas of your mouth are giving you discomfort, or you would like to improve? _____

I attest to the accuracy of the information on this page and give consent to the diagnostic procedures and treatment by the dentist for necessary and proper dental care. I consent to the disclosure of my records to carry out treatment, obtain payment, confirm appointments, and other functions relative to treatment or payment. I am aware of Dr. Buska's HIPPA Privacy Policy, I have been offered a copy of his policy, have signed the office copy, and have access to the policy through the dental office upon request. By signing this form, I am also agreeing to be responsible for payment of services.

Patient or Guardian's Signature: _____ Date: _____