

Timothy M. Lawrence, D.D.S., M.S., Inc.

PATIENT INFORMATION

Name _____ Birth Date ____/____/____ Age _____
Home Address _____ Apt. Number _____
City _____ State _____ Zip Code _____
Home Phone _____ Business Phone _____ Cell _____ E-mail _____
Sex: M F Marital Status: Single Married Divorced Widow Social Security # _____ - _____ - _____
Patient Employed by _____ Occupation _____
Business Address _____
Emergency contact name _____ Phone Number _____
Whom may we thank for referring you here today? _____
Who is your Dentist? _____ Who is your Orthodontist? _____

DENTAL INSURANCE INFORMATION

I have Dental Insurance
Primary Dental Insurance Company _____ Phone Number _____
Insurance Address _____
Primary Subscriber _____ Birth Date ____/____/____
Subscriber ID # _____ Policy Group # _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Primary Subscriber Employer _____ Business Phone _____

I have Secondary Dental Insurance
Secondary Dental Insurance Company _____ Phone Number _____
Insurance Address _____
Secondary Subscriber _____ Birth Date ____/____/____
Subscriber ID # _____ Policy Group # _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Secondary Subscriber Employer _____ Business Phone _____

MEDICAL INSURANCE INFORMATION

I have Medical Insurance
Primary Medical Insurance Company _____ Phone Number _____
Insurance Address _____
Subscriber _____ Birth Date ____/____/____
Subscriber ID # _____ Policy Group # _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Subscriber Employer _____ Business Phone _____

I have Secondary Medical Insurance
Secondary Medical Insurance Company _____ Phone Number _____
Insurance Address _____
Subscriber _____ Birth Date ____/____/____
Subscriber ID # _____ Policy Group # _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Subscriber Employer _____ Business Phone _____

I authorize payment of my dental/medical benefits directly to Timothy M. Lawrence, DDS, MS, Inc. for all services, also the use of this signature on all insurance submissions. I authorize Timothy M. Lawrence, DDS, MS, Inc. to release all information necessary to secure the payment of benefits.

Primary Dental Subscriber Signature: _____ Date: _____
Secondary Dental Subscriber Signature: _____ Date: _____
Primary Medical Subscriber Signature: _____ Date: _____
Secondary Medical Subscriber Signature: _____ Date: _____