David Garlock DMD MS PC
Orthodontic Specialist

PATIENT INFORMATION

Patient's Name_________________________________Nickname_______________Sex__________

Date of Birth_______________________

Home Address____

City, State, Zip_________________________________Home Phone_____________________________

General DDS_______________________ Email____________________________________

Referred By_______________________

Information for patients who are minors:

FATHER	MOTHER
Name_______________________________	Name___________________________________
Address______________________________	Address_________________________________
____________________________________	____
Work Phone__________________________	Work Phone_____________________________
Cell Phone___________________________	Cell Phone______________________________
SS#________________DOB___________	SS#__________________DOB____________
Drivers License #/State __________________	Drivers License #/State ______________________

Parent's Marital Status: Married____ Separated ____Divorced ____Widowed____ Single____

Insurance Information (Please fill out highlighted portion to verify eligibility):

Primary Insured Name_______________________ Date of Birth ____/____/________

Employer ________________ Name of Insurance Company _______________________

Member ID or SSN ________________ Group Number _______________

Signed ____ **Date** ____________________

Insurance Release (if applicable)

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_______________________________________ ___________________________
Authorized Signature of Covered Person/Employee **Date**