CHRISTOPHER STELLPFLUG, D.D.S.

Welcome! So that we may provide you with the best possible care,
Please fill this information form. All information is completely confidential.

PATIENT INFORMATION DATE_____

NAME _____

ADDRESS _____

_____

EMPLOYER _____ OCCUPATION _____

BIRTHDATE _____ DRIVER'S LICENSE _____

TELEPHONE _____SSN _____ MALE ___ FEMALE ___

BUSINESS/CELL_____ EMAIL ADDRESS _____

EMERGENCY CONTACT: NAME _____ PHONE _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER COMPANY
NAME_____

ADDRESS _____

POLICY NUMBER_____

AUTHORIZATION
I hereby authorize payment directly to Christopher Stellpflug, D.D.S. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost and dental treatment. I hereby authorize Christopher Stellpflug, D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE_____ DATE _____

OTHER INFORMATION

SPOUSE/RESPONSIBLE PERSON NAME _____

ADDRESS _____

EMPLOYER _____DRIVER'S LICENSE _____

BIRTHDATE _____ OCCUPATION _____

TELEPHONE/BUSINESS/CELL_____ SSN _____