Paul B. Lederman, DDS
Lederman and Lederman, DDS
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Bellevue, WA 98007
(425) 746-6020
www.drlederman.net

Patient Information

Date _____

___Mr. ___Mrs. ___Ms. ___Dr. First Name _____ MI___ Last Name _____

___Male ___Female Birthdate_____ Age____ SS#_____ Email_____

___Single ___Married ___Widowed Name you go by _____

Home Address _____ City _____ State ____ Zip _____

Home # (____)_____ Work # (____)_____ EXT._____ Cell # (____)_____

Employer _____ Employer address_____

Referred by_____ Other family members seen by us _____

Spouse name _____ Employer _____ Work # (____) _____

Spouse's SS# _____ Spouse's birthdate _____

DO YOU HAVE DENTAL INSURANCE? ___Yes ___No (Medicare does not cover dental procedures)

PRMARY DENTAL INSURANCE

Insurance company's name_____ Group #_____

Insurance company's address _____

Insurance company's # (____) _____ Who is the insured? ___self ___spouse ___mother ___father

SECONDARY DENTAL INSURANCE

Insurance company's name_____ Group #_____

Insurance company's address _____

Insurance company's # (____)_____ Who is the insured? ___self ___spouse ___mother ___father

In case of emergency contact name _____ Phone # (____) _____

Medical Doctor's name _____ Phone # (____) _____

ASSIGNMENT AND RELEASE

I herby authorize payment directly to Lederman and Lederman for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents I authorize the above dentist and or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____ / _____ / _____