Howard M. Achen, DDS
225 E Idaho #14
Las Cruces, New Mexico 88005
(505) 523-8663

I. Patient Information

Whom may we thank for referring you to our office?__________

Name:__________
(Last) (First) (Mi)

Address:__________

____
(Phone) (Cell) (E-mail)

Birth Date:______ Age:____ Sex:____ (M/F) Marital Status:____ (S/M/D/W) SS#______

Place of Employment:__________

Address:__________

Work Phone:______ Ext:____ Present Position:______

Spouse Name:__________ Birth Date:______
(Last) (First) (Mi)

Place of Employment:__________ SS#:______

Address:__________

Work Phone:______ Ext:____ Present Position:______

II. Billing Information (Person responsible for account if different from patient)

Name:__________ SS#:______
(Last) (First) (Mi)

Address:__________
(Number/Street) (Apt.#) (City) (State) (Zip)

Place of Employment:__________ Birth Date:______

Address:__________

Work Phone:______ Ext:____ Present Position:______

How is patient related to person responsible for account? Spouse Son Daughter Other______

It is our policy to receive payment for professional services when the service is rendered unless previous arrangements have been made.

III. Dental Insurance Information
(Please let the office know if you have a secondary insurance.)

Name:__________

Address:__________

Phone:______ Group#:______ E-Claim #______

Subscriber:______ Relation: Self Spouse Child Other______

ID# or SS#__________

Office Use Only

Max:______ Class A____ B____ C____ Dect:____ Applied to:____

Seals:______ PX: twice yrly____ every 6 ____Pano:____

SIGNATURE ON FILE AUTHORIZATION: I hereby authorize payment of insurance benefits directly to the Dentist and authorize release of any information concerning these claims.

____
(Date)

____
Signed (Patient, or parent if Minor)

HEALTH HISTORY