

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: _____ SS# _____
 (M/F)

II. Parent Information

Mother

Father

Name:		
Address:		
Home#		
Birthdate:		
S.S.#		
Employer:		
Address:		
Work:		

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# _____

Max: _____ Class A _____ Office Use Only 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

