Dr. Nick Withem Dental PLLC
467 Main St.
Oxford, Massachusetts 01540

Section I Patient Information: Please print Date:_____

Name: _____ Prefer to be called_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Work (_____) _____Cell (_____) _____

Date of Birth:_____ M or F Social Security Number:_____

Circle Appropriate Status: Minor Single Married Widowed Separated Divorced

If Student, Name of School: _____ City/State_____

Spouse or Parent's Name: _____ Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone: _____

Email Address_____

Section II Responsible Party

Relationship to Patient: Self Spouse Parent Other

Name: _____ Cell(_____) _____

Address: _____ City:_____ State: ____ Zip: _____

Employer:_____ Work (_____) _____ SSN # _____

Section III Insurance Information

Name of Insured_____ DOB_____ Relationship to Patient_____

SSN# _____Name of Employer: _____ Work (_____) _____

Insurance Company _____ Group #: _____ID# _____

Ins Co Address _____Ins Co Phone:(_____)_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ DOB _____ Relationship to Patient_____

SSN#:_____ Name of Employer:_____ Work (_____)_____

Insurance Company _____ Group#:_____ ID# _____

Ins Co Address _____ Ins Co Phone: (_____) _____

Assignment of benefits: I hereby authorize payment directly to the physician of benefits due for services. I understand I am financially responsible for charges not covered by this authorization.

Date Signature

Release of Information: I hereby authorize the physician and/supplier to release any information required to process this claim form,_____

Date Signature