Drs. Pfeffer, Palmer, Guletz, & Greaves
16 Hampton Village Plaza
Suite 229
St. Louis, MO 63109
314-353-1851

PATIENT INFORMATION

DATE_____

NAME_____ ○MARRIED ○SINGLE ○MINOR
LAST FIRST M ○MALE ○FEMALE

SOCIAL SECUIRTY #_____**EMAIL ADDRESS**_____

ADDRESS_____
STREET APT# CITY STATE ZIP

BIRTHDATE_____**TELEPHONE**_____
MONTH DAY YEAR HOME WORK CELL

NAME OF EMPLOYER_____**ADDRESS**_____

IF FULL TIME STUDENT, SCHOOL NAME_____**GRADE**_____

INSURANCE INFORMATION

MINOR CHILD- MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS- COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL EMAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER# GROUP#

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL EMAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER# GROUP#

EMERGENCY CONTACT

Name_____

Address_____

City/State/ZIP_____

Telephone #_____

How did you hear about our office?

- ○ Individual_____
- ○ Insurance Company
- ○ Facebook
- ○ Google/Yahoo
- ○ Yelp/YP.com
- ○ Other _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professional by any method, including electronic transfer.

X_____
Patient or Responsible Party