Zora Hanko
Doctor of Dental Medicine
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Patient Information

Name: _____ ☐ Male ☐ Female
(first) (initial) (last) (preferred name)

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age _____ Social Security # _____ Marital Status _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

How would you like us to confirm your appointments? ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Patient Employer/School: _____ Employer Address: _____

Who may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone: _____

Insurance Information

Person Responsible for Account: _____

Relation to Patient: _____ Birthdate: _____ Social Security # _____

Address (if different from patient): _____ Phone: _____

Responsible Person's employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Phone Number _____
Insurance Address: _____

Group # _____ Subscriber ID _____ Plan # _____

If the patient is covered by additional insurance, please provide the name and pertinent information:

_____

Signature

I certify that I, and/or my dependent(s) have insurance coverage with _____and assign all insurance benefits directly to Dr Zora S Hanko. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

_____ _____ _____
(Printed name of patient, parent, or guardian) (Signature of Patient, Parent, or Guardian) Date