

**Patient Information**

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First MI  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code

**Parent or Responsible Party Information**

Parent's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Parent's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_  
Phone (Cell): \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Insurance Information**

I don't have dental insurance.

**Primary**

Name of Insured \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Insurance Plan Name and Address: \_\_\_\_\_  
Insurance Plan Phone #: \_\_\_\_\_

**Secondary**

Name of Insured \_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Insurance Plan Name and Address: \_\_\_\_\_  
Insurance Plan Phone #: \_\_\_\_\_

**Assignment of Insurance Benefits and Release of Information**

I, the undersigned, certify that I (or my dependents) have dental insurance coverage and assign directly to Matthew Gustafsson, DDS, MS all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

\_\_\_\_\_  
(Responsible Party Signature)

By signing here I acknowledge that above is true and accurate to the best of my knowledge.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_