Robert R. Martin, D.D.S. 3150 Beard Rd. • Napa, CA 94558

ACCOUNT INFORMATION

Mr./Mrs./Miss/Ms. _____

First Name Middle Name Last Name

Prefered Name _____ Sex M / F Birthdate _____ SS# _____-_____-_____

Mailing Address _____

Street City State Zip

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Employer _____ Occupation _____

Email Address _____

Were you referred by one of our patients? Y / N

If Yes, Whom may we thank? _____

If no, How did you find us? _____

Special interests? _____

INSURANCE INFORMATION

Policy Holder _____ Subscriber # _____

Insurance Company #1 _____ Group Policy # _____

Insurance Company #1 Address _____

Policy Holder _____ Subscriber # _____

Insurance Company #2 _____ Group Policy # _____

Insurance Company #2 Address _____

I hereby authorize the release of any information including diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician, of insurance benefits to which I am intitled.

_____ Date _____

Signature of Patient / Responsible Party