Jason T. Beck, DDS, MD
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Phone: 254-537-1071 Fax: 254-537-1187
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PATIENT DEMOGRAPHICS

Name: _____ DOB: _____ Age: _____ Sex: M/F SSN: _____
Last First Middle Driver's License Number: _____
Address: _____
Number & Street / Apt. # City State Zip Code
Home Phone: _____ Cell Phone: _____ Height: _____ Weight: _____
Employment Status: Employed/Retired/Disabled/Student Place of Employment: _____
Marital Status: Single/Married/Widowed/Divorced Name of Spouse/Parent/Guardian: _____
Name of Parent/Guardian responsible for account: _____ Relation: _____
(If under the age of 18) Home Phone: _____ Cell Phone: _____
Address of Above: _____
Number & Street / Apt. # City State Zip Code
General Dentist: _____ Doctor or Person who referred you: _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Co. Name: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Insurance ID: _____
Insurance Group Number: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Insurance ID: _____
Insurance Group Number: _____

Primary Medical Insurance

Insurance Co. Name: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Insurance ID: _____
Insurance Group Number: _____

Secondary Medical Insurance

Insurance Co. Name: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber SSN: _____
Insurance ID: _____
Insurance Group Number: _____

I certify that the above information is true and accurate.
I consent to the taking of clinical photographs in the course of diagnostic and surgical procedures for the use of treatment.
I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating physician/dentist for the services provided. I also request payment of government benefits to the treating physician/dentist.
I agree to the financially responsible for all services rendered by the treating physician/dentist. A payment on account or an insurance copayment may be due at the time services are rendered. I will be financially responsible for all charges not covered by my insurance. I will pay all financial obligations in a timely fashion. I accept that delinquent accounts will be turned over to a collections agency after 90 days if payment is not made, or other special financial arrangements have not been made in certain circumstances

Signature of Patient/Guardian: _____ Date: _____