Lefkoff
PERIODONTICS
Maureen H. Lefkoff, DDS, MS, PA

Adult Patient Information Form

Patient Information

last name | first name | middle name | preferred name

street address | city | state | zip

home phone | work phone | cell phone | email

social security number | birth date (mm/dd/yyyy) | [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated | [ ] M [ ] F

occupation | employer

work address | city | state | zip

referred by | present dentist

emergency contact | phone

physician | phone

physician address | city | state | zip

Primary Dental Insurance

insured's name | insured's employer

insured's birth date | insured's social security number or identification number | relationship to patient

insurance company | phone number | group number

insurance company address | city | state | zip

Secondary Dental Insurance

insured's name | insured's employer

insured's birth date | insured's social security number or identification number | relationship to patient

insurance company | phone number | group number

insurance company address | city | state | zip

I authorize Dr. Lefkoff to release any information requested by any third party payer regarding charges incurred by this patient. In addition, I authorize the use of the signature on all insurance submissions.

Signature | Date

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