

## Dental Insurance Information

Please bring with you:

Insurance Card (MetLife does not have a card)

Current Student Status Form (If college student) This can be downloaded from your college's web site. (Techsis for Tech students.)

Since it takes a while to confirm your insurance benefits, we can shorten your time in the office if you will provide the following information before your appointment:

Name of the Insured \_\_\_\_\_

Insurance Identification Number \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_

Date and time of Appointment \_\_\_\_\_

Please fax to: (806) 794-2433 or  
Email to: [info@lubbockdentist.com](mailto:info@lubbockdentist.com)

We look forward to seeing you and are committed to making your visit as pleasant as possible.

The next to pages provide us with information to make your visit as productive and safe as possible. Please complete them and bring them with you or fax them to (806) 794-2433.

Thanks



# Dr. Rodger McCuiston, DDS

Date \_\_\_\_\_

**Patient Information (Confidential)** Home# \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State / Zip \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City / State \_\_\_\_\_

Patient's or Parent's Employer \_\_\_\_\_ Work # \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone # \_\_\_\_\_

**Responsible Party** Relationship \_\_\_\_\_

Name of Person Responsible for this Account \_\_\_\_\_ To Patient \_\_\_\_\_

Address \_\_\_\_\_ Home # \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

Payment is due at time services are rendered. For your convenience, we offer the following methods of payment:  
Insurance (Your "estimated" portion will be due), Cash, Check, MasterCard, Visa & Discover.

**Insurance Information** Relationship \_\_\_\_\_

Name of Insured \_\_\_\_\_ To Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work # \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_ To Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work # \_\_\_\_\_

**Patient Medical History**

Physician \_\_\_\_\_ Office # \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

		Yes	No
1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			
4. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OVER PLEASE



