Independence Dental
Kenneth R. Winokur, DMD, PC
329 South Main Street
Independence, OR 97351

PATIENT INFORMATION

Name: _____ Birthdate: _____ Male ☐ Female ☐
Last First Middle
Local Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different): _____
Home Phone: _____ Cell Phone: _____ Day Phone: _____
E-mail address: _____
Student Status: _____ Full Time ☐ Part Time ☐ Name of School: _____
Student Permanent Address (if different): _____
Employer: _____ Occupation: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____
Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐

RESPONSIBLE PARTY INFORMATION

Name: _____ SS#: _____-_____-_____ Birthdate: ___ /___ /___ Relation: _____
Local Address: _____ City/State/Zip: _____
Mailing Address (if different): _____ City/State/Zip: _____
Home Phone: _____Cell Phone: _____ Day Phone: _____
E-mail address: _____
Name of Spouse or other person not listed above:
Spouse/Parent Name: _____
SS#: _____-_____-_____ Birthdate: ____ /____ /____ Relation: _____
Address: _____ City/State/Zip: _____

IN CASE OF EMERGENCY, PERSON TO CONTACT OTHER THAN PARENT/SPOUSE

Name: _____ Relation: _____
Address: _____ Day Phone: _____ Cell Phone: _____

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Name of Insured: _____	Name of Insured: _____
Insured Birthdate: _____	Insured Birthdate: _____
Insured Id: _____	Insured Id: _____
Employer: _____	Employer: _____
Group Id: _____	Group Id: _____
Relation to Patient: _____	Relation to Patient: _____
Name of Insurance Company: _____	Name of Insurance Company: _____
Insurance Address: _____	Insurance Address: _____
Insurance Phone #: _____	Insurance Phone#: _____
Effective Date:_____	Effective Date: _____

I authorize the release of this information including diagnoses and records of any treatment or examination rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and claim submission and reimbursement assigned directly to Kenneth R. Winokur, DMD, any insurance benefit to which I am entitled. I also understand that based on the services rendered I am financially responsible for this account, including service fees or finance charges for overdue balances and missed appointments, and that I am required to pay for my services.

Signature of Patient (18 or older):_____ Date: _____/_____/_____
Signature of Parent/Guardian:_____ Date: _____/_____/_____