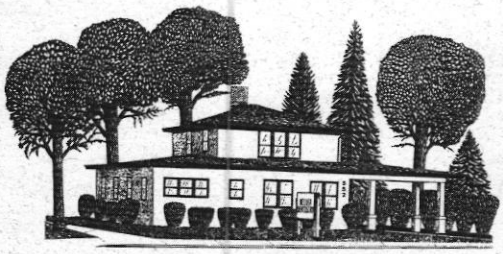

Welcome To Our Practice

John J. Keller D.D.S.
Megan M. Vasko D.D.S.

552 East Main Street • Anoka, MN 55303

PATIENT INFORMATION

Date _____

Patient's Name _____

Date of Birth _____

If Child: Parent's Name _____

How do you wish to be addressed? _____

Street Address _____

City _____ State _____ Zip _____

Email _____

Do you want appointment notifications by text / email? Y N

Telephone Home _____

Cell Phone _____ Bus. _____

Social Security No. _____

Patient's Employer Name _____

Present Position _____

How Long Held _____

Spouse / Parent Name _____

Spouse / Parent Employed By _____

Spouse / Parent Phone No. _____

Present Position _____

How Long Held _____

Who is responsible for this account? _____

Method of co-payment: Check____Cash____Credit Card_____

Emergency Contact Name _____

Home # _____ Cell # _____

Relationship _____

Other family Members in this Practice _____

_____

Whom may we thank for the referral _____

DENTAL Primary Coverage

Employee Name _____

Employee Date of Birth _____

Social Security No. _____

Employer Name _____

Insurance Co. Name: _____

Insurance Co. I.D.#. _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

DENTAL Secondary Coverage

Employee Name _____

Employee Date of Birth _____

Social Security No. _____

Employer Name _____

Insurance Co. Name: _____

Insurance Co. I.D.#. _____

Insurance Co. Phone No. _____

Insurance Co. Address _____

Group / Policy No. _____

Union / Local _____

PATIENT AUTHORIZATION

I have seen or been given the "Notice of Privacy Practices" from Dr. Keller and Dr. Vasko's office and am aware of my privacy rights.

HIPAA - by signing this form, you will consent to our use and disclosure of your health information to carry out treatment, payment activities and health-care operations.

I hereby authorize payment of health insurance benefits directly to the dentist, otherwise payable to me. I understand I am financially responsible for payments in full of all accounts.

I consent to the use of my x-rays, records and dental photos for scientific publication or teaching providing my name and identity remain anonymous.

Patient or Guardian's Signature _____ Date _____