Jeffrey L. Katz, D.D.S. Mina Levi, D.D.S
586 Washington ST.
San Francisco, CA 94111

Patient Information Record

Dr.
Mrs.
Ms.
Mr. _____ Date of Birth_____

Street Address _____

City/State/Zip_____

Home Phone _____ Driver's License_____

Work Phone _____ Social Security #_____

Employed by _____Occupation _____

Work Address _____

City/State/Zip _____

E-Mail Address: _____

Status (X): Married ( ) Single ( ) Divorced ( ) Widow/er ( ) Minor ( )

Spouse _____Date of Birth _____ S.S. # _____

Occupation _____ Employed by _____ Work # _____

Name, Relationship and phone # of the person to notify in an emergency:

Who may we thank for referring you to our office? _____

Last dental visit was _____ Last time x-rays were taken _____

Previous Dentist's Name & Phone # _____

Purpose of today's visit _____

Responsible party for payment _____Date of Birth _____
Address _____City/State/Zip _____

Employed by _____Work # _____

S.S.# _____

Insurance
Insurance Company _____ Plan Name _____
Address _____City/State/Zip _____
Group # _____Phone # _____

I, the undersigned, have insurance coverage with the above named carriers, and assign directly to Dr. Jeffrey L. Katz all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed _____ Date _____