

M.M. Van Benschoten, O.M.D, CA, Inc.

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Patient Information

Please Print

_____ M F _____
Patient Name Date of Birth Age

_____ City State Zip Home Phone #

_____ Work Phone # Pager or Cell #

_____ Social Security Number Drivers License

Legal Guardian or Responsible Party Information

_____ Relationship Social Security Number

_____ City State Zip

_____ Home Phone # Work Phone #

Other family members that have been seen in our office.

Who referred you to our office? _____

We supply itemized statements for insurance purposes.

Please be considerate of other patients and notify us at least 24 hours in advance of any cancellations, or you will be charged a full office visit.

I understand that full payment for the office visit and supplies are my responsibility and not that of the insurance company and are due at the time of service. I have read and understand the 24hr cancellation policy.

_____ Date

Signature of Responsible Party (Must be over 18 years of age)