

WELCOME!

Thank you for selecting our South Texas Periodontal Associates healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your needs, please fill out this form as completely as possible. This information is required in order for our office to file claims with your dental benefit provider. If you have any questions or need assistance, please ask! We will be happy to help.

Name of Insured _____ DOB _____

Is Patient a Full Time Student? _____ School _____ City _____

Insured Mailing Address _____

City, State, Zip _____

Relationship to Patient _____ SS# _____

Date Employed _____ Name of Employer _____

Union or Local # _____ Work Phone _____

Address of Employer _____

City, State, Zip _____

Insurance Company _____ Group # _____

Policy ID # _____

Insurance Company Address _____

City, State, Zip _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTISTS OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature of Insured _____ Date _____

Adam Christman MS DDS MSD (License #29522)
Fraser Graham DDS (License #11750)

Brian Beck DDS MS (License #15287)

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