# NORTH PENN DENTAL ARTS

**Stanley J. Heleniak D.M.D.**

Date: _____

**Patient Information** (CONFIDENTIAL) SSN: _____

Name: _____ Birth date: _____ MALE or FEMALE

Address: _____

City: _____ State: _____ Zip: _____ Home phone: _____

Cell phone: _____ Email: _____

Would you like to receive appointment alerts via text messages? YES NO via email? YES NO

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College: _____ City: _____ State: _____

☐ Full Time ☐ Part time

Spouse or Parent/Guardian's Name: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you? _____

**Responsible Party**

Name of person responsible for this Account: _____

Relationship to patient: _____ DOB: _____

Cell #: _____ Home #: _____ Email: _____

Address: _____

Employer: _____ Work #: _____

SSN: _____ Is this person currently a patient in our office? YES NO

We offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Discover ☐ AmEx ☐ CareCredit

**Insurance Information**

Name of Insured: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Home #: _____

Name of Employer: _____ Work #: _____ Cell #: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How much is your deductible?: _____ Max. Annual Benefit: _____ How much have you used?: _____

Do you have any other dental insurance? YES NO If yes, please complete the following:

Name of Insured: _____ Relationship to patient: _____

DOB: _____ SSN: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Work #: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

*Over Please*