Roberto V. Pischek, DMD, PC,
21400 Highway 59, Robertsdale, AL 36567
(251) 947-5811

TODAY'S DATE_____

Patient's Name_____

Date Of Birth_____ Male_____ Female_____

Mailing Address_____

Physical Street Address_____

City_____ State_____ Zip Code_____

Home Phone #_____Work Phone #_____

Cell #_____ E-mail Address_____

If a child, Legal Guardian's Name_____ Relationship to Child_____

Patient's Social Security Number_____

Patient (or Parent) Employed by_____ Phone # _____

Spouse Name _____

In Case of an Emergency, Who Should Be Notified Other than Parents or Guardian _____

Relationship to Patient _____ Phone Number _____

If child, Parent's Social Security Number _____

Name of Primary **DENTAL** Insurance Company _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security Number _____

Subscriber's Employer _____

Whom May We Thank for Referring You _____

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I, hereby grant permission to release information of my health history, status, treatment, copies of my records, x-rays, and any test results to my health care provider, insurance company, and its agents. I hereby assign all primary and insurance benefits to Roberto V. Pischek, DMD, PC. I agree to personally guarantee payment for professional services rendered, and further agree to pay all costs of collection including, but not limited to, court costs and reasonable attorney's fees.
Signature _____ **Date**_____

I, hereby grant permission for Dr. Roberto V. Pischek to treat the above named patient, as he deems medically necessary.
Signature _____ **Date**_____

Our office policy does not allow us to accept third party payments. Thank you.