**Allyson Bauch-Friedrich, D.D.S.**
**1702 E. Airline Rd.**
**Victoria, TX 77901**

**Date _____**

## Patient Information

**Name**_____ **Home Phone**_____
**Address**_____ **Work Phone**_____
**City**_____ **State**_____ **Zip**_____ **Cell Phone**_____
**Age**_____ **Birthdate** _____ **Sex** M F **E-mail**_____
**Preferred Name** _____ **Social Security No.**_____
**Driver's License No.**_____ **Marital Status**_____
**In case of emergency notify**_____ at (  )_____ - _____
**Whom may we thank for referring you**_____
**Medical doctor's name**_____ **Date of last visit** _____
**Pharmacy** _____

## Responsible Party Information

**Name**_____ **Home Phone**_____
**Address**_____ **Work Phone**_____
**City**_____ **State**_____ **Zip**_____ **Cell Phone**_____
**Age**_____ **Birthdate** _____ **Sex** M F **E-mail**_____
**Social Security No.**_____ **Driver's License No.**_____

## Insurance Information

**Name of Insured** _____ **Relationship to patient** _____
**Insured SS#** _____ **Insured Birthdate** _____
**Employer** _____ **Insurance Company** _____
**Subscriber ID#** _____ **Group#** _____
**Medicaid ID#** _____ **MCNA**_____ **DENTAQUEST** _____
**CHIPS ID#** _____ **MCNA**_____ **DENTAQUEST** _____

**I understand that I am responsible for any remaining balance that my insurance company does not cover.**

**Signature** _____ **Date** _____