Philip A. Lisk, D.D.S., P.A.
901 Paverstone Dr., Ste. A Raleigh, NC 27615

Confidential Patient Information

(Please Print Legibly)

Date: ______________________________

PERSONAL INFORMATION

Name: ______________________________ SS #: ______________________________

Address:

____

City: ______________________________ State: __________ Zip: _______________

Telephone: (Home) ______________________________ (Work) ______________________________

(Cell) ______________________________ e-mail: ______________________________

Birth date: _____________ Sex: _____ Marital Status: ______________ Spouse Name: ____________________

Occupation: ______________________________ Referred by: ______________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________________ Relationship: ______________ SS #: _________________

Address:______________________________

City: ______________________________ State: ________ Zip: ____________

Telephone: (Home) ______________________________ (Work) ______________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co:

____

Insurance Co.
Address:______________________________

Employee: ______________________________ Relationship: _________________ S.S. #: _____________

Employer: ______________________________ Policy #: _______________________

Secondary Insurance Co:

____

Insurance Co. Address:

____

Employee: ______________________________ Relationship: _________________ S.S. #: _____________

Employer: ______________________________ Policy #: _______________________

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: DATE: