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: