Steven E. Lynn, D.D.S.
2920 McIntire Drive, Suite 200
Bloomington, IN 47403

Patient Information:

Name_____ Age____ Birthdate_____ Sex_____

Address_____ City/State_____ Zip_____

Telephone( )_____ Cellular( )_____ SSN_____

Marital Status: Single Married Widowed Divorced Occupation_____

Employer_____ Employer Address_____ Phone_____

Whom may we contact in case of emergency?_____ Phone_____

How did you hear about our office?_____ Do you desire a

courtesy call prior to your appointments? Yes___ No___ If yes, at what number?_____

Responsible Party Information:

Name_____ SSN_____ Birthdate_____

Relationship to Patient_____ Address_____

City/State_____ Zip_____ Employer Phone_____

Employers Name & Address_____

Dental Insurance Information:

Insurance Co._____ Member Name_____

Employer_____ Address_____

ID#_____ Group#_____ Insured Birthdate_____ SSN_____

Secondary Insurance Co_____ Employer_____

Name of Insured_____ SSN_____ Birthdate_____

ID#_____ Group#_____

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization including all fees incured in collecting the dental fees. I authorize release of dental/medical information for insurance purposes. I understand that if my insurance company has not paid within 60 days, the dental fees become my responsibility. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information. The parent who requests treatment and is present with a minor child at the time of treatment is responsible for all service rendered.

_____ Date _____

Signature of Patient or Parent if Minor