REBECCA A. HAVEL DDS, SC

Please check the box with the location you are seeing Dr. Rebecca A. Havel DDS, SC.

Algoma ☐ **Green Bay** ☐

Print and Complete All Entries

Patient Information

Patient Name(Last, First, MI):

D.O.B:

Patient SSN:

Address:

City, State:

ZIP Code:

Home Phone:

Cell Phone:

Sex: ☐ **M** ☐ **F**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other**

Employer Information

Patient's Employer:

Employer's Address (City, State, ZIP):

Employer's Phone:

Insured/Responsible Party Information

Name (Last, First, MI):

D.O.B:

SSN:

Address (if diffrent from patient):

Home Phone:

Cell Phone:

Relationship To Patient: ☐ **Spouse** ☐ **Parent** ☐ **Guardian**

Employer:

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Primary Insurance

Insurance Name:

Insurance Phone:

Address:

City, State, ZIP:

Group Number:

ID Number:

Employer Name:

Employer Phone:

Seconday Insurance

Insurance Name:

Insurance Phone:

Address:

City, State, ZIP:

Group Number:

ID Number:

Employer Name:

Employer Phone:

Doctor & Emergency Contact

Primary Doctor/Family Doctor:

Referring Doctor:

In Case of Emergency Contact:

Relationship:

Phone Number:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient. If minor, signature of parent or guardian)

Date: