DAVID C. CAMP, D.D.S.
NATHAN M. HEUBNER, D.D.S.
RIVER RIDGE PROFESSIONAL BLDG.
700 N. THIRD STREET
BURLINGTON, IOWA 52601
(319) 752-1840

(PLEASE PRINT)

REGISTRATION

NAME: ______________________________ BIRTHDATE ____ / ____ / ____ SEX: ________
FIRST INITIAL LAST MO DAY YEAR

NAME YOU WISH TO BE ADDRESSED BY ______________________________ SS# ______________

HOME ADDRESS: ______________________________
STREET CITY STATE ZIP

EMPLOYED BY: ______________________________ JOB POSITION: ______________________________
(LIST IF FULL TIME STUDENT) (LIST SCHOOL NAME IF FULL TIME STUDENT)

BUSINESS ADDRESS: ______________________________
STREET CITY STATE ZIP

TELEPHONE: HOME (   ) ______________________________ BUSINESS: (   ) ______________________________

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED REFERRED BY: ______________

SPOUSES NAME: ______________________________ CHILDREN: ______________________________

PERSON RESPONSIBLE FOR ACCOUNT

❑ SAME AS ABOVE

NAME: ______________________________ RELATIONSHIP ______________ SS# ______________
FIRST INITIAL LAST

HOME ADDRESS: ______________________________
STREET CITY STATE ZIP

EMPLOYED BY: ______________________________ JOB POSITION: ______________________________

BUSINESS ADDRESS: ______________________________
STREET CITY STATE ZIP

TELEPHONE: HOME (   ) ______________________________ BUSINESS: (   ) ______________________________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE CO: ______________________________
NAME

EMPLOYEE BIRTHDATE

MO	DAY	YEAR

____
STREET CITY STATE ZIP

EMPLOYEE NAME: ______________________________ RELATIONSHIP TO PATIENT: ______________ SS# ______________
FIRST INITIAL LAST

EMPLOYER: ______________________________ POLICY NUMBER: ______________________________

SECONDARY DENTAL INSURANCE CO: ______________________________
NAME

EMPLOYEE BIRTHDATE

MO	DAY	YEAR

____
STREET CITY STATE ZIP

EMPLOYEE NAME: ______________________________ RELATIONSHIP TO PATIENT: ______________ SS# ______________
FIRST INITIAL LAST

EMPLOYER: ______________________________ POLICY NUMBER: ______________________________

I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claims.

______________________________ ______________________________
Signature of patient (If minor, signature of parent) Date