**RONALD F. KONOPKA, D.D.S.**

Date_____ New Patient Information

Name _____ Birth date _____ Soc. Sec. No. _____

Address_____ Phone Hm _____ Cell _____Wk _____

City and Zip_____ Employer_____

Single ___ Married___ Divorced ___ Widowed ___

Spouse's Name _____Birth date_____ Soc. Sec. No._____

Spouse Employed By_____

Referred By_____

Name of Relative or Friend (Not at same address) _____

Address _____

Person Responsible for Account _____

Address (if different than above) _____

Dental Insurance

(Yours) _____

(Spouse's)_____

I hereby authorize payment directly to the dentist of insurance benefits otherwise payable to me. I also authorize the dentist to release any information relating to this claim.

Signature _____