Patient Information

Page 1

Pham Dentistry
NORTH BEND

Patient Information

First Name * Jacqueline

Last Name * Jeambey

Middle Initial A

Title

Preferred Name Jackie

Date of Birth * 09/14/1993

Gender * ○ Male ◉ Female

Social Security Number 360-88-0388

Address * 45505 SE 150th st

City * North Bend

State * WA

Zip Code * 98045

Home Phone (___) ___-____

Cell Phone (630) 470-2262

Work Phone (___) ___-____

Email jackiejeambey@gmail.com

Employer High line school district

Occupation

Marital Status * ◉ Single ○ Married ○ Divorced ○ Widowed ○ Seperated ○ Domestic Partner

Do you prefer to be contacted for appointment confirmation via e-mail or phone? * ◉ Email ○ Phone

How did you hear about our office?

Page 2

Responsible Party Information

First Name

Last Name

Relationship to Patient

Date of Birth mm/dd/yyyy

SSN/ID ___-__-____

Phone Number (___) ___-____

Employer

Spouse Name

Spouse's SSN/ID ___-__-____

Spouse's Employer

Spouse's Date of Birth mm/dd/yyyy

Insurance

Subscriber First Name Jacqueline

Subscriber Last Name Jeambey

Relationship to Patient Self

Date of Birth 09/14/1993

Subscriber SSN/ID

360-88-0388

Subscriber Employer

High line school district

Insurance Company

Delta dental

Insurance Phone Number

(800) 650-1583

Group Number

09601

Insurance Company Address

P.O. Box 75983

City

Seattle

State

WA

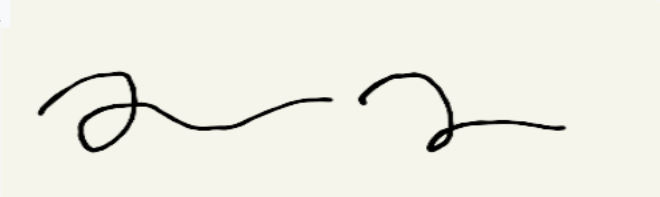
Zip Code

98175

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pham Dentistry all medical and/or dental insurance benefits, or third party payer, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I also acknowledge that any account that goes beyond 60 days past due will be transferred to Transworld Systems Inc. for accounts receivable assistance. Should this be necessary, a service fee/rebilling fee will be added to my account of at least $25. Interest may be applicable. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature *



Today's Date

09/23/2023

Relationship