TODD WHITLOCK, D.D.S.
3925 Hagan Street, Suite 201
Bloomington, IN 47401
(812) 332-0052

Patient Information

Name________________________ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Date of Birth____________ Age______ SS#____________

Home Address________________________ City____________ State______ Zip________

Email Address____________________ Home Phone____________________

Work Phone________________ext.______ Fax____________________

Pager #____________________ Cell Phone____________________

Employer/School____________________ Occupation____________________

Employer Address____________________ City____________ State______ Zip________

Person Responsible for Account________________________ Phone____________

Billing Address________________________ City____________ Zip________

Spouse/Guardian's Name____________________ Employer____________________

Spouse/Guardian's Occupation____________________ Work Phone____________________

Insurance Information

Name of Insured____________________ Date of Birth____________ SS#____________

Insurance Co. Name________________________ Phone____________

Name of Employer Group Plan____________________ Policy #____________________

Claim Filing Address____________________ City____________ State______ Zip________

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of information to all my insurance carriers.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize payment directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Payment Options

Please check preferred option:

- ☐ Visa/MasterCard
- ☐ Cash
- ☐ Check

Signature on File________________________ Date____________

Consent: I grant authority to TODD WHITLOCK, D.D.S. to perform dental procedures and treatments that may be necessary.

Signature________________________ **Date**____________

Please Share With Us...

How were you referred to our office? ________________________

Previous dentist____________________ Date of last dental visit____________________

Your childrens' names and ages: ________________________

What would it take to keep you as a long term patient in our practice? ________________________

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