Denton Combs
Center For Excellence In Care

Phone: 605-274-3898 • Fax: 605-274-3899
5124 S. Western Avenue, #4
Sioux Falls, SD 57108

ACCOUNT # _____

PATIENT INFORMATION

PLEASE PRINT

NAME: _____ BIRTHDATE: _____
Last First Nickname Middle

HOME ADDRESS: _____
Street City State Zip

PHONE: (Home)_____ (Cell)_____ (Work) _____

SOCIAL SECURITY #: _____ SEX: Male Female MARITAL STATUS: S WID DIV. M
Circle One

Insurance _____ Secondary Insurance_____

Preferred Communication: ☐ Cell ☐ Home ☐ Work ☐ Email E-MAIL: _____

EMPLOYER: _____

AN EMERGENCY CONTACT: Relationship:_____ Name_____ Phone_____

How did you find out about our practice? _____

SPOUSE'S NAME: _____ BIRTH DATE: _____
Last First Middle

EMPLOYER: _____ WORK PHONE: _____ SOC. SEC. NO.: _____

(If patient is a minor) MOTHER/GUARDIAN

SOCIAL SECURITY #: _____

NAME: _____ BIRTHDATE: _____
Last First Middle

RELATIONSHIP TO PATIENT: _____

CELL PHONE:_____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ EMPLOYER: _____
Street City State Zip

(If patient is a minor) FATHER/GUARDIAN

SOCIAL SECURITY #: _____

NAME: _____ BIRTHDATE: _____
Last First Middle

RELATIONSHIP TO PATIENT: _____

CELL PHONE:_____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ EMPLOYER: _____
Street City State Zip

AUTHORIZATION FOR TREATMENT: I the undersigned give my authorization to treat and assign directly to DENTON COMBS, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

_____ _____
Patient / Patient's Representative Relationship to Patient

_____
Date