

FRED J. HERMANSON, D.D.S., PA  
CAM TU N. DALLUGE, D.D.S.  
7300 West 147<sup>th</sup> St. Ste. 302  
Apple Valley, MN 55124

WE WOULD LIKE TO GET TO KNOW YOU BETTER!

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by \_\_\_\_\_

Name \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
First MI Last DOB

Address \_\_\_\_\_  
Street City State Zip Code

S.S. # \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_ Female \_\_\_ Marital status (circle) S M W D Sep

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer name/ address \_\_\_\_\_

Occupation \_\_\_\_\_

Person responsible for payment of account: self \_\_\_ Other \_\_\_\_\_

---

**INSURANCE POLICYHOLDER'S INFORMATION (if different than patient's)**

Name \_\_\_\_\_ S.S.# \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

---

Primary Ins. \_\_\_\_\_ Secondary Ins. \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

ID # \_\_\_\_\_ ID # \_\_\_\_\_

**Primary Policyholder name** \_\_\_\_\_ DOB \_\_\_\_\_

**Secondary Policyholder name** \_\_\_\_\_ DOB \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ phone # \_\_\_\_\_

I hereby request and authorize direct insurance payments to Fred J. Hermanson, D.D.S., PA. I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for my balance regardless of insurance. I understand that if I have no insurance I will be asked to pay the cost of the services at the time I am seen. This form also authorizes the release of any dental information to other providers and/or insurance companies involved in my dental care.