Patient Information

Patient Last Name:_____ First Name:_____ M.I._____

Patient Address Line 1:_____
Patient Address Line 2 (Apt#, Lot#, Suite):_____
City_____ State:_____ Zip:_____-_____
Preferred Name (Nickname):_____ Email Address_____
Guarantor (Person responsible for paying bill):_____
Whom may we thank for referring you to our office?:_____
Employer Name & Address _____
_____
Purpose of this visit:_____

Home Phone:_____ Work Phone:_____

Mobile Phone:_____ Social Security#_____

Birthday:_____ Gender: Male_____ Female_____

Dental Insurance Information

Primary Subscriber: _____
Subscriber:_____
Employer: _____
Address:_____
City:_____ State:_____ Zip:_____
Social Security # _____

Date of Birth _____

ID# _____

Secondary

Employer:_____
Address:_____
City:_____ State:_____ Zip:_____
Social Security #

Date of Birth

ID# _____

Group Number: _____

Group Number:_____

Insurance Carrier: _____
Carrier_____
Address:_____
City:_____ State:_____Zip:_____
Phone #:_____

2nd Insurance

Address:_____
City:_____ State:_____Zip:_____
Phone #:_____

I will allow Dr. Stroud/Dr. Wilson/Dr. Thompson/Dr. McMurry to photograph (x-ray) and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physician and to request medical information from him/her.

I understand that where appropriate, credit bureau reports may be obtained.

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient
Parent/Guardian_____ Date:_____