



ROD R SPENCER, DDS, LLC

NEW PATIENT INFORMATION FORM

Name (Last, First, Middle): _____ MARITAL: S / M / D / W

HOME ADDRESS: _____

PREFERRED NAME: _____ SS NO: ____ / ____ / ____ DOB: ____ / ____ / ____ SEX: M / F

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

REFERRING DOCTOR: _____ REFERRING PATIENT: _____

MEDICAL ALERTS: _____ EMERGENCY CONTACT # _____

EMAIL ADDRESS: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

SS NO.: ____ / ____ / ____ EMPLOYER: _____

DOB: ____ / ____ / ____ ADDRESS: _____

PLAN NAME: _____ GROUP NUMBER: _____

INSURANCE COMPANY: _____ IND. YRLY. DEDUCT: _____

ADDRESS: _____ FAM. YRLY. DEDUCT: _____

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be dispersed to my insurance plans subscriber, myself or spouse. I am financially responsible for any balances due and authorize the dentist to submit dental claims on my behalf as well as any information needed to process this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers, before and after photos, or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: X _____ Date: _____