2 Sided form

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information (please print)

Name_____ Date_____

I prefer to be called_____ ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.

Address_____ City_____ State_____ Zip_____

Birthdate_____ Age_____ Home#_____ Work#_____ Cell#_____

S.S. #_____ Do you prefer to receive calls at: ☐Home ☐Work ☐Cell ☐Other

Are you: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer_____ Occupation_____

Business Address_____ City_____ State_____ ZIP_____

Spouse's or Parent's Name_____ Workplace_____

Work #_____ S.S. #_____ Birthdate_____

Whom may we thank for referring you to us_____

Contact person in case of emergency_____ Home#_____ Wk#_____ Cell#_____

Present Dentist_____

Responsible Party

Name of person responsible for this account_____

Relationship to Patient_____ Home#_____ Cell#_____

Business Address_____ City_____ State_____ Zip_____

Name of Employer_____ Work#_____

Primary Dental Insurance (please provide copy of card)

Insurance Co. Name_____ Group/Policy#_____

Insurance Co. Address_____ Phone#_____

Insured's Name_____ Relationship to Patient_____

Insured's Birthdate_____ Insured's SS#_____ Member ID#_____

Insured's Employer or Group Name_____

All payment is due in full at the time of treatment
(unless prior arrangements have been approved)

I understand that I am responsible for all costs of dental treatment. I authorize insurance benefits otherwise payable to me to be paid directly to Dr. Thomas W. Mabry. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I am fully aware that regardless of insurance benefits, I am ultimately responsible for any balance incurred.

_____

Signature Date

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

For your convenience we accept: Cash, Discover, MasterCard and Visa

Our office is HIPAA compliant and committed to meeting or exceeding the standards of Infection Control mandated by OSHA, the CDC and the ADA