PATIENT INFORMATION

Today's Date: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____

❑ Male ❑ Female Birthdate: _____ Age: _____

Home Address: _____
Apt/Condo#

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Cell Phone: _____

Home Phone: _____

Work Phone: _____ Ext: _____

E-mail: _____

Preferred method of contact: ❑ Phone ❑ Text ❑ Email

Best time to reach you: _____

Whom may we thank for referring you? _____

_____

Employer's Name: _____

Employer's Address:

_____
City State Zip

Occupation: _____

Second Person Responsible for Account/Spouse:

Name: _____ Birthdate: _____

Employer: _____

Home Address: _____

Work Phone: _____ Home Phone: _____

Relationship: _____

Billing Address: _____

Primary Dental Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

ID#: _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____

Birthdate: _____ Relationship: _____

Insured's Employer: _____

Secondary Dental Insurance:

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

ID#: _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____

Birthdate: _____ Relationship: _____

Insured's Employer: _____

In the event of any emergency, whom should we contact?

Name: _____

Relationship: _____

Work Phone: _____

Home Phone: _____

Family Members

Patient Name	Date of Birth	Sex Select	Age
Patient Name	Date of Birth	Sex Select	Age
Patient Name	Date of Birth	Sex Select	Age
Patient Name	Date of Birth	Sex	Age

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit all dental claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize payment directly to Murray Scholls Family Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including the diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.

Name*(Please print)***:** _____

Signature: _____ **Date:** _____

MURRAY SCHOLLS FAMILY DENTAL

Scott R. Walker, DMD

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