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	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	Age
Patient Name	Date of Birth	Sex	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:** ____________________

Scott R. Walker, DMD

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