

Patient Information

Date _____

Patient's Name _____
Last First Middle

Birth Date _____ Sex _____

Social Security Number _____ Texas Drivers License Number _____

Address _____ Apartment Number _____

City _____ State _____ ZIP _____ How Long? _____

Home Phone Number _____ Work Phone Number _____

Cell Phone Number _____ E-Mail Address _____

Spouse's Name _____
Last First Middle

Spouse's Social Security Number _____ Spouse's Birth Date _____

Spouse's Work Phone Number _____

Previous Address _____ Apartment Number _____

Previous City _____ State _____ ZIP _____

Name and address of nearest relative not living with you

_____ Last First Middle

_____ Street Address

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Dental Insurance

PRIMARY CARRIER - Patient's Insurance

Company _____ Group Number _____

Name of Insured _____ Social Security Number of Insured _____

SECONDARY CARRIER - Spouse's Insurance

Company _____ Group Number _____

Name of Insured _____ Social Security Number of Insured _____

EMPLOYMENT

Occupation _____ Spouse Occupation _____

Company Name _____ Company Name _____

How Long? _____ How Long? _____

Address _____ Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. If I do not pay the entire balance, or if insurance is unpaid after 90 days, I agree to a billing charge of 1.5% per month equaling 18% per annum. In the case of default of payment, I agree to pay any and all costs associated with the collection of this account by a 3rd party agency and/or attorney fees and court costs. I understand where appropriate, credit reports may be obtained prior to the extension of terms of credit.

Signature

Date