Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us.
We will be happy to help.

Patient # _____

Soc. Sec. # _____

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birth date _____ Home Phone _____

Address _____ City _____ State ____ Zip _____

Email address _____ Cell phone _____

Check Appropriate Status:

____ minor ____ single ____ married ____ divorced ____ widowed ____ separated

If Student, Name of School _____ City _____ State ____ Zip _____

_____ Full time student _____ Part time student

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State ____ Zip _____

Spouse or Parents Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's License # _____ Birth date _____ Financial Institution _____

Employer _____ Work Phone _____ SS # _____

Is this person currently a patient in our office? _____ Yes ____ No

For your convenience, we offer the following payment options. Please check the option you prefer. Payment in full is expected at each appointment. I understand that my insurance is an agreement between myself and my insurance company. I also understand that I am responsible for my balance regardless of my insurance. Thank you for your cooperation.

____ Cash ____ Personal Check _____ Visa ____ MasterCard ____ Discover ____ AMEX

____ I wish to apply for outside credit.

Over Please

Insurance Information

Name of Insured _____ *Relationship to Patient* _____

Birth date _____ *SS #* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* ____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Insurance Company Address _____ *City* _____ *State* ____ *Zip* _____

How Much is your deductible? _____

How much have you used? _____

Maximum Annual Benefit _____

I understand that my insurance is an agreement between myself and my insurance company. I also understand that I am responsible for my balance regardless of my insurance. I assign dental benefit payments to be paid directly to Dr. Joseph B. Brogdon from my insurance company.

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ *YES* _____ *NO*

IF YES COMPLETE THE FOLLOWING:

Name of Insured _____ *Relationship to Patient* _____

Birth date _____ *SS #* _____ *Date Employed* _____

Name of Employer _____ *Union or Local #* _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* ____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Insurance Company Address _____ *City* _____ *State* ____ *Zip* _____

How Much is your deductible? _____

How much have you used? _____

Maximum Annual Benefit _____

I give my permission for this office to use any before and after photos, or study models (stone models of your teeth) for internal promotional purposes, teaching lectures, presentations, or publication.

Patient Signature _____ *Date* _____