PATIENT'S NAME: _____ DATE OF BIRTH: _____

RESPONSIBLE PARTY

Today's Date: _____ E-Mail Address _____

Name: _____

Birth date: ___/___/___ AGE: _____ SS# _____

Home Adress: _____

_____

Relationship to Patient: _____

Single Married Divorced Widowed Separated

HM # (___) _____ CELL # _____

WK # (___) _____ Ext: _____

Driver's License # _____

Employer: _____

Occupation: _____

Where & When are the best times to reach you?

_____

Whom may we thank for referring you?

_____

Other family members seen by us:

_____

Patient's Previous Dentist: _____

Patient's Last Visit: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (___) _____

Group # _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's SS# _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (___) _____

Group # _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's SS# _____

Insured's Employer: _____

SPOUSE INFORMATION

HIS/HER Name: _____

Employer _____

WK# _____ Ext. _____ Birth date: ___/___/___

SS# _____ Driver's License # _____

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I understand that Andrew R. Fletcher, DDS is not a preferred provider for any dental insurance and would only be considered at the out-of-network benefits.

Signature: _____
Date: _____