REYNOLDS DENTISTRY

PATIENT INFORMATION

NAME:_____DATE OF BIRTH _____SS#_____

PHONE: (HOME) _____(CELL)_____(WORK)_____

ADDRESS _____CITY_____STATE_____ ZIP_____

EMERGENCY CONTACT PERSON _____PHONE # _____

EMAIL ADDRESS_____HOW DID YOU HEAR ABOUT OUR OFFICE ? _____

EMPLOYMENT INFORMATION

The following is for: The Patient ___ The person responsible for payment ___

EMPLOYER NAME _____ _____OCCUPATION _____

ADDRESS: _____CITY_____STATE____ZIP_____

DRIVER LISCENSE #_____DATE OF BIRTH _____SS# _____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURED: _____DATE OF BIRTH _____

LAST FIRST MIDDLE

ID #_____ GROUP # _____SSN#_____

INSURED'S ADDRESS: _____ CITY _____STATE _____ ZIP_____

INSURED'S EMPLOYER NAME: _____

ADDRESS: _____CITY _____STATE _____ZIP _____

PATIENT'S RELATIONSHIP TO INSURED: Self ___ Spouse ___ Child ___ Other ____

INSURANCE PLAN NAME AND ADDRESS: _____

_____

_____

CONSENT FOR SERVICES

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fees charged. To avoid misunderstanding concerning payment of accounts, please note that payments and copays are required in full, unless satisfactory arrangements have been made in advance. Our office does charge for duplication of records and or xrays. There is also a $35.00 return check charge along with any bank fees; payment is then due in cash or money order.

I agree to pay any collections fees (attorney fees and court costs) required in the process of collection of a delinquent account.

If you are unable to keep your appointment, kindly give the office 48 hours' notice. Otherwise we reserve the right to charge for the time reserved.

Signature _____**Date** _____