| MEDICAL ALERT | |
|---|---|

**WE MAKE EVERY EFFORT TO GET TO KNOW OUR PATIENTS IN THE SHORT TIME WE HAVE WITH YOU, PLEASE HELP US BY COMPLETING THE FOLLOWING:**

Mr. Mrs. Miss _____ _____

Local Address: _____ City/State:_____Zip_____

Home Phone: _____Cell Phone: _____ Email Address:_____

Permanent Address:_____ City/State: _____ Zip: _____

Birth Date: ____/____/____ Your Age: _____ Occupation: _____

Employed By: _____ Work Phone: _____

Drivers Lic. #: _____ State Issued: _____

Social Security #: _____ Family Physician Name/Phone_____

Name of Parent/Guardian/Spouse: _____ Phone: _____

(Please circle one)

**WHO MAY WE THANK FOR YOUR REFERRAL?** _____

Subscribers Name: _____ Subscribers SS#_____

Date of Birth: _____ Name of Dental Program:_____

Group #: _____ Maximum Annual Benefit: _____ Deductible:_____

Address of Program: _____ City/State/Zip: _____

Phone: _____

PAYMENT POLICY

Please remember, the patient not the insurance company is responsible for payment for all professional services rendered. Payment is due at time of service unless prior arrangements have been made. Please check preferred method of payment:

___ Cash ___ Check ___Visa ___Mastercard ___ CareCredit (Credit card for Dentistry)

Initial _____