

Mark R. Stephenson, DDS

Date \_\_\_\_\_

**PATIENT INFORMATION**

Married  Single  Minor  Male  Female

Name \_\_\_\_\_  
LAST FIRST MID.

Address \_\_\_\_\_  
STREET APT.  
CITY STATE ZIP

DOB \_\_\_\_\_ SS# \_\_\_\_\_  
MONTH/DAY/YEAR

Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

EMAIL \_\_\_\_\_

Has anyone in your family been treated here before?

YES  NO

Can we thank someone for referring you to our office?

Name \_\_\_\_\_  
LAST FIRST

**FAMILY INFORMATION**

**FATHER or GUARDIAN (If applicable)**

Name \_\_\_\_\_  
LAST FIRST MID.

Address \_\_\_\_\_  
STREET APT.  
CITY STATE ZIP

DOB \_\_\_\_\_ SS# \_\_\_\_\_  
MONTH/DAY/YEAR

Phone# \_\_\_\_\_ Work# \_\_\_\_\_

EMAIL \_\_\_\_\_

Employer \_\_\_\_\_

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

**EMPLOYER and INSURANCE**

PLACE OF EMPLOYMENT

DENTAL INSURANCE CARRIER

INSURANCE CLAIMS ADDRESS

INSURANCE CITY STATE ZIP

SUBSCRIBER ID NUMBER GROUP NUMBER

Insurance Phone # \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name \_\_\_\_\_  
LAST FIRST MID.

Work# \_\_\_\_\_ Home# \_\_\_\_\_

**MOTHER (If applicable)**

Name \_\_\_\_\_  
LAST FIRST MID.

Address \_\_\_\_\_  
STREET APT.  
CITY STATE ZIP

DOB \_\_\_\_\_ SS# \_\_\_\_\_  
MONTH/DAY/YEAR

Phone# \_\_\_\_\_ Work# \_\_\_\_\_

EMAIL \_\_\_\_\_

Employer \_\_\_\_\_

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

**METHOD OF PAYMENT**

Responsible party has an account with this office?

YES  NO

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (credit card)

Card# \_\_\_\_\_ Exp. Date \_\_\_\_\_

I wish to discuss the Dental Office's Financial Policy

*Service Charge: For any bill not paid in full within 25 days of the monthly billing date, a service charge of 1.5%/month (18% yearly rate) will be added to the bill based on the current balance. In case of default, charges will include interest, collection fees, and attorney fees if required.*

**AUTHORIZATION**

**Person Responsible for the Account - Check one:**

*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 the dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.*

X \_\_\_\_\_ Seal  
 Patient  Guardian  Father (Husband)  Mother (Wife)

STATE DRIVER'S LICENSE # DATE

**NOTE:** We require 24 hours notice for a cancelled appointment. This gives us time to find someone else to fill the timeslot. We bill \$1.00/minute for appointments missed without notice.

Initials \_\_\_\_\_