Mark R. Stephenson, DDS

Date _____

PATIENT INFORMATION

☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Name _____ (LAST) _____ (FIRST) ____ (MID.)

Address _____ (STREET) ____ (APT.)

_____ (CITY) _____ (STATE) _____ (ZIP)

DOB _____ (MONTH/DAY/YEAR) SS# _____

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)

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# _____

FAMILY INFORMATION

FATHER or GUARDIAN (If applicable)

Name _____ (LAST) _____ (FIRST) ____ (MID.)

Address _____ (STREET) ____ (APT.)

_____ (CITY) _____ (STATE) _____ (ZIP)

DOB _____ (MONTH/DAY/YEAR) SS# _____

Phone# _____ Work# _____

EMAIL _____

Employer _____

_____ (DENTAL INSURANCE CO.) _____ (SUBSCRIBER #) _____ (GROUP #)

MOTHER (If applicable)

Name _____ (LAST) _____ (FIRST) ____ (MID.)

Address _____ (STREET) ____ (APT.)

_____ (CITY) _____ (STATE) _____ (ZIP)

DOB _____ (MONTH/DAY/YEAR) SS# _____

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 appiointment. This gives us time to find someone else to fill the timeslot. We bill $1.00/minute for appointments missed without notice.*

Initials _____