PATIENT INFORMATION

PATIENT

NAME (LAST,FIRST,M.I.)

ADDRESS

CITY ZIP CODE

EMPLOYER

MO / DA / YR / / BIRTHDAY

M F SEX

S M W D MARITAL STATUS

- - SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME WORK

EMPLOYER ADDRESS

PERSON RESPONSIBLE FOR ACCOUNT

GUARANTOR

☐ SAME AS ABOVE

NAME (LAST,FIRST,M.I.)

ADDRESS

CITY ZIP CODE

EMPLOYER

MO / DA / YR / / BIRTHDAY

M F SEX

S M W D MARITAL STATUS

- - SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME WORK

EMPLOYER ADDRESS

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

INSURANCE

PRIMARY CARRIER INFORMATION

PATIENTS RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD

NAME OF INSURED

EMPLOYER

EMPLOYER ADDRESS

MO / DA / YR / / BIRTHDAY

M F SEX

- - SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME WORK

INSURANCE COMPANY ADDRESS GROUP/LOCAL NUMBER

IS PATIENT A FULL TIME STUDENT? ☐ YES ☐ NO SCHOOL NAME

SECONDARY CARRIER INFORMATION (SPOUSE'S INSURANCE)

PATIENTS RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD

NAME OF INSURED

EMPLOYER

EMPLOYER ADDRESS

MO / DA / YR / / BIRTHDAY

M F SEX

- - SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME WORK

INSURANCE COMPANY ADDRESS GROUP/LOCAL NUMBER

OTHER

FORMER DENTIST LAST DENTAL VISIT

REFERRED BY

By signing this form, I/we authorize the release of information regarding this claim to my insurance carrier or hospitals or other doctors who have treated the above patient. I further assign payment directly to Dr. Carol McCutcheon by signing this form. I acknowledge that **I AM RESPONSIBLE FOR ALL MONIES DUE DR. MCCUTCHEON NOT PAID BY MY INSURANCE**, for services rendered as described in this/these claim(s). A service charge of 1 1/2% will be charged on all accounts after 60 days. There is a $10.00 returned check charge.

SIGNATURE DATE