MONTEVALLO FAMILY DENTISTRY

REGISTRATION/HISTORY

Date_______________

Patient's Name _______________ Single ____ Widowed ____ Married ____ Divorced ____ Separated ____

Name of Spouse _______________

If a Child, Parent's Name _______________

Street Address _______________ Phone _______________

City _______________ State _______________ Zip _______________

Patient Employed by _______________ Phone _______________

Business Address _______________

Present Position _______________ How long held _______________

Spouse Employed by _______________ Phone _______________

Business Address _______________

Present Position _______________ How long held _______________

Purpose of this appointment _______________

In case of Emergency, who should be notified _______________ Phone _______________

Who will pay this account _______________

Social Security Number _______________ Birthdate _______________

Spouse's Social Security Number _______________ Birthdate _______________

Do you have insurance that may cover any part of our professional services..Yes_________ No_______

If so, name of primary company _______________ Policy No. _______________

Social Security No. of Policy Holder _______________

Do you have any other insurance.. Yes_________ No_______

If so, name of secondary company _______________ Policy No. _______________

Social Security No. of Policy Holder _______________

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _______________

To the best of my knowledge all of the preceding answers are true and correct. I understand that I am responsible for all charges, whether or not paid by my insurance. I also agree to pay all additional expenses, such as attorney fees, incurred for the collection of any past due amount. I hereby waive my rights of exemption under the laws of Alabama or any other state.

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Signature of patient, parent or guardian Date