Broken Arrow Family Dentistry *** 2024 ***

Thank You for Choosing Our Practice for Your Dental Care!

PATIENT:

Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Cell Phone: (____) _____ Email:_____

Birthdate: _____ Social Security Number: _____ Male ___ Female ___

Employer _____ Occupation _____

RESPONSIBLE PARTY: Please complete any information that is different than that shown for the patient.

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Cell Phone: (____) _____ Email:_____

Birthdate: _____ Social Security Number: _____ Male ___ Female ___

Employer _____ Occupation _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Cell Phone: (____) _____ Email:_____

PRIMARY Policy Holder Name: _____ Birthdate: _____

Relationship: _____ SS#: _____ ID#: _____

Employer: _____ Phone: (____) _____

Group #: _____ Group Name: _____

Insurance Co: _____ Phone: (____) _____

SECOND Policy Holder Name: _____ Birthdate: _____

Relationship: _____ SS#: _____ ID#: _____

Employer: _____ Phone: (____) _____

Group #: _____ Group Name: _____

Insurance Co: _____ Phone: (____) _____

I agree to paying the estimated patient's share at the time of service. I understand that a monthly service charge of 1½ % (18% annually) may be added to any balance not paid within 30 days.

_____ _____ _____

Signature of Patient or Guardian Relationship to Patient Date