MARY BENNETT HOUSTON DDS, PA

PATIENT INFORMATION **DATE** _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Sex M_____ F_____ Minor _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Cell Phone _____ Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parents Name _____

Best telephone number to reach you for appointments _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for the Account _____

Address (if different from patient) _____

Phone (if different from patient) _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

INSURANCE INFORMATION (PRIMARY INSURANCE)

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# or ID# _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Address _____ City _____ State _____ Zip _____

ADDITIONAL INSURANCE (SECONDARY INSURANCE)

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# or ID# _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Address _____ City _____ State _____ Zip _____