

# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.



6142 U.S. Highway 98, Suite 10  
Hattiesburg, MS 39402  
Phone: (601) 450-1123  
Fax: (601) 450-1127



## Patient Information

Date _____	Pt. # _____	Home Phone (____) _____					
Name _____	Last Name _____	First Name _____	Initial _____	Soc. Sec. # _____			
Address _____							
City _____	State _____	Zip _____					
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birthdate _____	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced
I prefer to be called: _____		Other family members seen by us: _____					
Business Address _____		Business Phone (____) _____					
Whom may we thank for referring you? _____							
In case of emergency who should be notified? _____		Phone (____) _____					



## Primary Insurance

Person Responsible for Account _____	Last Name _____	First Name _____	Initial _____
Relation to Patient _____	Birthdate _____	Soc. Sec. # _____	
Address (if different from patient's) _____		Phone (____) _____	
City _____	State _____	Zip _____	
Person Responsible Employed By _____		Occupation _____	
Business Address _____		Business Phone (____) _____	
Insurance Company _____			
Contract # _____	Group # _____	Subscriber # _____	
Names of other dependents covered under this plan _____			



## Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.  
I authorize the dentist to release all information necessary to secure the payment of benefits.  
I understand that I am financially responsible for all charges whether or not paid by insurance.  
I understand if I am unable to keep my appointments, I must kindly give 24 hours notice, or I will be charged a cancellation fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

Please Complete Both Sides

