

UPDATED BY PATIENT

1. ___/___/___ _____
 2. ___/___/___ _____
 Date Pt's initials

OFFICE USE ONLY

1. ___/___/___ _____ ___/___/___ _____
 2. ___/___/___ _____ ___/___/___ _____
 3. ___/___/___ _____ ___/___/___ _____
 Date Div I initials Date Div IV initials

OFFICE USE ONLY

Date ___/___/___
 Acct. # _____

ADULT PATIENT INFORMATION

Name _____
 Last First Middle Name Birth Date Age Sex

Address _____
 Number & street Apt.# City State Zip Code

How long have you resided at this address? _____ Yrs. _____ Months Rents _____ or Owns _____

Home Ph _____ Work Ph _____ ext _____ Mobile Ph _____
 (Please check the BEST daytime phone #)

E-mail Address _____

Name, Address, and Phone Number of person responsible for payment of this account (If same as above, please omit.)

Are you: Married _____ Spouse's Name _____ Single _____ Divorced _____ Widowed _____

Your Place of Employment _____ Position _____

Length of employment _____ Yrs. _____ Months Address of Employment: _____

Spouse's Employment _____ Position _____

Length of employment _____ Yrs. _____ Months

Address of Employment _____ Spouse's Business Phone _____

Your Social Security Number _____ / _____ / _____ Spouse's Social Security Number _____ / _____ / _____

Have other members of your immediate family been here before? Yes No Relationship _____

Reason for today's visit _____

Have you been told by a physician that you need an antibiotic premed before receiving any dental treatments? YES NO (please circle)

If yes, what medication is recommended by your doctor? _____ For what medical condition? _____

Please list the name and phone number of a close friend or close relative **NOT RESIDING WITH YOU** who we may contact in case of an emergency or if we are unable to contact you.

Name Relationship Phone #

DENTAL INSURANCE

As a courtesy to you, we will file for primary dental insurance to your company. In order to do this, we must have one completed and signed form on file per patient **per calendar year**. If your insurance company has not remitted payment within 60 days of the date of service, the balance will be due and payable by the patient. Please complete the following information regarding dental insurance.

Primary **Dental** Insurance Company _____ Phone # _____

Mailing Address _____

Employee: _____ S.S # _____ / _____ / _____ Group # _____ Subscriber's Birth date: _____ / _____ / _____

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Dr. Bentley and his Associates to discuss my conditions with my physician and to request medical information for him. I authorize the office of Mark T. Bentley, D.D.S., Inc. or his agent to obtain and verify a credit report. I understand that there will be a fee for any broken appointment or any appointment cancelled less than 24 hours, unless is an emergency.

CREDIT POLICY

A \$25.00 rebilling fee will be charged for each month your balance is overdue. A balance is overdue if not paid within 60 days from the DATE OF SERVICE, regardless of insurance coverage. I understand that any legal fees incurred by this office in collection of the accounts balance will be my responsibility. Type of payment: CASH _____ CHECK _____ -Driver's License # _____ CREDIT CARD _____

Patient's Signature _____

If you are completing this form for another person, Please sign below and indicate your relationship to the patient.

Signature _____ (husband, wife, mother, father, etc.)