

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 _____

Circle all of the ways which motivated you to choose our office: TV RADIO INTERNET NEWSPAPER MAILING EVENT _____

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 #
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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.)