

Donald L. Taylor, Jr., D.D.S.
PATIENT INFORMATION FORM

PATIENT _____ Age _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

If student, grade _____ School/College _____

RESPONSIBLE PARTY _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____ Ext. _____

Relation _____ Social Security Number _____ Date of Birth _____

SPOUSE _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Spouse's Employer _____ Work Phone _____ Date of Birth _____

Whom may we thank for referring you? _____

Whom may we contact in the event of an emergency? _____

Relationship _____ Home Phone _____

Previous Dentist _____ Last Visit _____

Insurance Company (1) _____ Subscriber _____

Group Number _____ I.D. Number _____

Insurance Company (2) _____ Subscriber _____

Group Number _____ I. D. Number _____

I WILL BE PAYING TODAY BY: Cash _____ Check _____ Credit Card _____ (Please check one)

I agree that I am ultimately responsible for any account balance for services rendered. I certify that the above information is true and correct to the best of my knowledge. In the event that my account has to be referred for collection, I agree that I am responsible for any and all costs of collection fees, which is 33.33% of the balance, or legal fees, which may be up to 50% of the amount due. I acknowledge that I have read and understand the terms of this agreement.

Responsible Party's Signature _____ Date _____

I hereby give authorization that all third-party payments of my/our dental benefits (Insurance, etc.) otherwise payable to me or my family be made directly to Donald L. Taylor, Jr. D.D.S.

Responsible Party's Signature _____ Date _____