# *Woodyard Dental Care, PSC*

Today's Date:

## PATIENT INFORMATION

Patient's Last Name | First | Middle | Preferred Name

Home Address | Mailing Address (If Different) | City | State | Zip | County

/ / | M F | - - | ( ) - | ( ) -

Date of Birth | Sex | Social Security No. | Home Phone No. | Cell No.

@ | Cell Phone Carrier | Single Married Widow Divorced_ Separated

Marital Status

Is it Acceptable to contact you by text and /or email? Y/N

Place of Employment | Occupation | ( ) - Work Phone No. | ( ) - Pager No.

Spouse/Parent | Home Address | - - Social Security No.

Spouse/Parent Place of Employment | Occupation | / / Date of Birth | ( ) - Work Phone No.

Other Family Members Seen In Our Office_____

Referred By: _____

## DENTAL INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Patient's Relationship to Subscriber | Name of Dental Insurance Company

Group No. | Address of Insurance Company | City | St | Zip | Phone No.

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address) | Relationship to Patient | ( ) - Home Phone No. | ( ) - Work Phone No.

**I HEREBY ACKNOWLEDGE THE FOLLOWING TERMS**: The above information is true to the best of my knowledge. I ACCEPT FULL RESPONSIBILITY FOR ALL TREATMENT PERFORMED BY THE DOCTORS AND DENTAL STAFF. Payment to Woodyard Dental Care, PSC is due, in full, at the time services are rendered. Insurance coverage is a contractual arrangement between myself and my insurance company only. Should my account become more than thirty days past due, I will be responsible for all fees for services rendered, monthly interest charges of 1.5% (eighteen percent per annum) with a minimum charge being $5.00, late fees, and all costs of collection, including but not limited to attorney fees and court costs (in the amount of 33.33% of my account balance). Should I choose to finance my costs of treatment through an outside agency, I will make all necessary arrangements PRIOR TO SERVICES BEING RENDERED. I give permission for information and photographs gained from my treatment to be used in clinical and economic research, practice marketing, and patient education activities/materials, provided that my identity is not reasonably discernible. Fees of $25.00 will be charged per returned check. You are subject to charges of $40 per hour for all appointment cancellations with less with than 2 business days notice

X _____

PATIENT/GUARDIAN SIGNATURE (REQUIRED) DATE