

Welcome to the office of Curtis J. Perry, D.D.S.

Please give us some information about yourself

PLEASE PRINT

Patient Name: _____ Mr./Mrs./Ms./Dr.: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M__F__ Date of Birth: _____ Social Security Number: _____ - _____ - _____

Driver's License Number (ID to verify who you are): _____ Email: _____

Method of Payment: Credit Card _ Cash _ Insurance _ Finance _

Name of a relative (for emergencies): _____

Address: _____

Phone: _____

If you are a student: Full / Part time School's name & location: _____

Name of Employer: _____ Occupation: _____

Address of Employer: _____

Person responsible for account: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Whom can we thank for this referral: _____

DENTAL INSURANCE INFORMATION

PolicyHolder's Name: _____ Sex: M__F__ Relation: _____

Policy Holder's Social Security Number: _____ Birthdate: _____

Name of Insurance Company: _____

Address: _____ Telephone: _____

Group Number: _____ Local: _____ Policy: _____

If you have a secondary insurance coverage please fill this in:

PolicyHolder's Name: _____ Sex: M__F__ Relation: _____

Policy Holder's Social Security Number: _____ Birthdate: _____

Name of Insurance Company: _____

Address: _____ Telephone: _____

Group Number: _____ Local: _____ Policy: _____

Co-Payment: Due at the time of service.

Appointments: Appointment time reserved for you requires two business days for cancellation or reschedule to avoid a minimum charge of \$30 per half hour.

Insurance: To avoid misunderstandings regarding dental insurance, we wish our patients to know that payment for all professional services rendered are the responsibility of the patient (or guardian). We will prepare necessary forms or reports to help you obtain your benefits from your insurance company.

Billing: There is a \$1 fee per billing statement and 1½% per month finance charge on balances past 30 days.

Print patient name: _____

Patient signature (or guardian): _____ Date: _____



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