# DECATUR DENTAL SERVICES
# PATIENT INFORMATION

**Date:**_______________ **Social Security #**_____-___-_____

**Patient's Name:**_______________________________________ **Birth Date:**_______________

**Address:**_____________________________ **City:**_______________ **State:**____ **Zip:**__________

**Home Phone:**_______________ **Cell Phone:**_______________ **E-mail:**__________________

**Who is responsible for your account?** ☐**Self** ☐**Spouse** ☐**Mother** ☐**Father** ☐**Other**

**Name:**___________________________ **Birth Date:**__________ **Social Security #**_____-___-_____

**Address:**___________________________ **City:**_______________ **State:**____ **Zip:**__________

**Phone #**______________________ **How long at this address?**____________

**Employer:**_________________________ **How Long?**__________ **Wk.Phone#**_______________

**Spouse's Name:**_____________________ **Birth Date:**__________ **Social Security #**_____-___-_____

**Spouse's Employer:**_____________________________________ **How Long?**_______________

**Decatur Dental requires payment in full for all services rendered at the time of each visit, unless other arrangements have been made. If unpaid, your account will be turned over to a collection agency. The person responsible for this account must pay all additional charges incurred in collecting your account balance.

## INSURANCE

**Who carries the Dental Insurance?** ☐**Self** ☐**Spouse** ☐**Mother** ☐**Father** ☐**Other**

**Name:**_____________________ **Employer:**_______________ **Social Security #**______-____-_______

**Insurance Company:**____________________ **Group#**____________ **ID#**__________________

**Who carries Secondary Dental Ins?** ☐**Self** ☐**Spouse** ☐**Mother** ☐**Father** ☐**Other,**
**Name:**_____________________ **Employer:**_______________ **Social Security #**______-____-______

**Secondary Ins. Co.:**____________________ **Group#**____________ **ID#**__________________

## EMERGENCY CONTACT

**Emergency Contact Name:**_______________________________ **Phone #**_________________

## CREDIT REPORT

**I agree to allow Decatur Dental Services to obtain a Credit Report if needed to establish an account:**
**Signature:**__________________________________________________ **Date:**______________