MARK BUILDER DMD
General and Family Dentistry
123 S.E. Douglas St.
Newport, OR 97365-0080

Patient's full name _____ Birthdate _____ / _____ / _____

Mailing address _____ Home Ph # _____

_____ Work Ph # _____

Patients Social Security # _____ Cell Ph# _____

Name of spouse/parent/guardian _____ E-Mail _____
(circle one)

Previous dentist _____ Last treatment _____ / _____
Name City Mo. Yr.

Whom may we thank for referring you to us? _____

PERSON RESPONSIBLE FOR ACCOUNT

_____
Name Address City PH#

Soc. Sec. No. _____ Employer _____

Years with employer _____ Work Ph # _____ Drivers License # _____

(THERE IS A 15% APR FINANCE CHARGE ON ACCOUNTS 30 DAYS PAST DUE)

Date_____ Signed _____

EMERGENCY NOTIFICATION

Name_____Ph. # _____Relationship _____

FOR PATIENTS WITH DENTAL INSURANCE

Insured person's name _____ I.D. #_____

Insured date of birth_____/ _____/ _____

Insurance company & Employer:_____ Group/Policy # _____

Coverage is for: ❑ Self ❑ Spouse ❑ Dependents

If a second dental insurance policy exists, please complete the following —

Insured person's name _____ Soc. Sec. No. _____

Insured date of birth_____/ _____/ _____

Insurance company & Employer:_____ Group/Policy # _____

Coverage is for: ❑ Self ❑ Spouse ❑ Dependents

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies.

This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled.

Date_____ Signed _____