

WELCOME

Date: ____/____/____

Referred By _____

Thank you for selecting the office of Dr. Mark Freeman & Associates

(All information will be kept strictly confidential)

Patient Information:

Name _____

Social Security # _____

Address _____

Date of Birth ____/____/____

City _____ State _____ Zip _____

Gender: Male _____ Female _____

Home Phone _____

Marital Status: Single _____ Married _____

Work Phone _____

Employer _____

Cell Phone _____

Spouse / Emergency Contact _____

Social Security # _____

Cell Phone _____

Date of Birth ____/____/____

Work Phone _____

Employer _____

If College Student, School's Name _____ City _____ State _____

Year Started _____ Full Time _____ Part Time _____

Email Address _____ (Would you like e-mail confirmations?) Yes _____ No _____

Responsible Party for Account: (If different from above)

Name _____

Social Security # _____

Address _____

Date of Birth ____/____/____

City _____ State _____ Zip _____

Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Is this person currently a patient in our office? Yes _____ No _____

Dental Insurance:

Primary Insurance Company _____

Policy # _____ Social Security # _____

Employer _____ Group # _____

Relation to Patient _____

Secondary Insurance Company _____

Policy # _____ Social Security # _____

Employer _____ Group # _____

Relation to Patient _____

Payment is expected at time of service.

For your convenience we offer the following methods of payment (please check your preference):

___ Cash ___ Check ___ Charge Card

___ I wish to speak to someone about your payment plans through *Visa* or Dental Fee Plan