HEAD OF HOUSEHOLD INFORMATION

NAME_____

ADDRESS_____

SS#_____DATE OF BIRTH_____

HOME PHONE_____WORK PHONE_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____

MARITAL STATUS: SINGLE_____MARRIED_____

SPOUSE NAME_____

SS#_____DATE OF BIRTH_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____WORK PHONE_____

DEPENDENTS: NAME_____DATE OF BIRTH_____

NAME_____DATE OF BIRTH_____

NAME_____DATE OF BIRTH_____

Do you have insurance that may cover any part of our services? YES_____NO_____

If so, what is the name of the person insured?

_____

Primary insurance company name: _____

ADDRESS_____

PHONE_____GROUP #_____

Secondary insurance company name: _____

ADDRESS_____

PHONE_____GROUP #_____

I authorize release of any information relating to insurance claims and understand I am responsible for all costs of dental treatment and authorize payment directly to the office of Dr. Mark E. Evans. Should any outstanding balance become a collection problem; I authorize the office of Dr. Mark E. Evans, to release my records to its contracted collections service. If you are not active in our hygiene program for continuous care after 3 years, you will be considered as an inactive patient with our practice.

SIGNATURE: _____