

HAROLD C. PEEPLES, D.D.S., P.C.
Practice limited to Oral and Maxillofacial Surgery

PATIENT FULL NAME: _____ MALE FEMALE SS# _____

STREET ADDRESS: _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE: _____ AGE: _____ RACE: _____ HOME PHONE: _____ EMAIL _____

EMPLOYER: _____ WORK PHONE: _____ CELL PHONE: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ WORK PHONE# _____

FATHER'S NAME:(IF MINOR) _____ EMPLOYER: _____ WORK PHONE# _____

MOTHER'S NAME:(IF MINOR) _____ EMPLOYER: _____ WORK PHONE# _____

REFERRED BY: _____ FAMILY DENTIST NAME: _____

FAMILY PHYSICIAN'S NAME: _____ PHONE: _____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION:

SUBSCRIBER NAME _____ BIRTHDATE _____ SS# _____

RELATIONSHIP TO PATIENT: _____ ADDRESS (if Different from Patient's) _____

INSURED'S EMPLOYER _____ Medical Insurance? YES NO Dental Insurance? YES NO

Is Patient a Full-Time Student? YES NO WHERE? _____

INSURANCE: If you have insurance, your company will be billed by our office; however, your deductible and co-pay will be payable on the day of office visit/surgery. If no insurance involved, full payment is expected.

PAYMENT: We accept most major credit cards for your convenience, along with personal checks.

WE DO NOT HOLD CHECKS NOR ACCEPT POSTDATED CHECKS.

In the event my account is placed with an outside agency for collection, I agree to pay all collection costs, court costs, and attorney fees incurred. Carrying a balance with this office constitutes a credit transaction and as such I authorize you, or your agent, to report credit activity to the credit bureaus. I also authorize you or your agent to check for address and employment should that be necessary to effect collection

PAYMENT WILL BE MADE TODAY: CHECK _____ CASH _____ CREDIT/DEBIT CARD _____ CARE CREDIT _____

I understand the above and accept the responsibilities as stated.

SIGNED: _____

DATE: _____

I AUTHORIZE MY INSURANCE COMPANY TO PAY TO THE DENTAL GROUP ALL INSURANCE BENEFITS OTHERWISE, PAYABLE TO ME FOR SERVICES RENDERED I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

SIGNATURE _____ DATE _____