(Please print clearly)

Julie O. Childers, D.M.D., P.A.

PATIENT INFORMATION

Patient Name ______________________ Nickname ______________________

Social Security # ______________________ Date of Birth ______________________

Street Address ______________________

Mailing Address (if different) ______________________

City ______________________ State ______________ Zip ______________

Home Phone ______________________ Business Phone ______________________

Occupation ______________________ Employer/School ______________________

Business Address ______________________ City ______________ State ______________ Zip ______________

☐ Single ☐ Married Spouse Name ______________________

Are other family members patients in our office? ☐ yes ☐ no

If yes, please list ______________________

Person responsible for payment (if not patient) ______________________

Street address ______________________ Relation ______________________

City ______________________ State ______________ Zip ______________

How will this account be paid? ☐ cash ☐ check ☐ mastercard/visa

Who recommended our office? ______________________

Previous dentist name ______________________ City ______________________

DENTAL INSURANCE INFORMATION

Our office will fill out an insurance form and accept payment from your Insurance Company for their part of your dental fee, IF you complete the following information. YOU must pay the balance of the fee at the time of treatment. We can also request a predetermination of your benefits from your insurance before beginning any extensive treatment. We cannot accept out-of-state or international insurance.

Employee or Insured's Name ______________________ D. O. B. ______________

Employer Name ______________________

Insured Soc. Sec. # ______________________

Insurance Company Name ______________________

Address ______________________

Street City St. Zip

Please sign if you would like our office to receive payments directly from your insurance company. You will be responsible for the balance of your fee.

Signature ______________________ Date ______________________