MITCHELL & CROSBY FAMILY DENTISTRY

Personal information

Patient Last Name First Middle Date of Birth

Mailing Address City State Zip Primary Phone

Social Security # _____ Sex M / F Marital Status: Single / Married _____
Name of Spouse (If Applicable)

Student Status: Y / N If Yes, Where? _____ _____
Patient Email

Emergency Contact _____Emergency Contact Phone_____

If you are completing this form for another patient,
What is your relationship to patient? _____

RESPONSIBLE PARTY

Name	Relationship to Patient
Address	Driver's License #
City	Social Security #
Employer	Primary Phone #
Work Phone	E-mail

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
Insurance Company	**Insurance Company**
Name	Name
Address	Address
ID# Group#	ID# Group #
Name of Insured	Name of Insured
Insured SSN Insured DOB	Insured SSN Insured DOB

This is a fee for service office. Payment is due at the time of service. If you have insurance, your estimated portion is due at that time. There is a $25.00 fee for returned checks. Insurance submissions returned due to incorrect information will result in a $10 fee assessed to your account for resubmission.
I have read and understand the financial policies of this office. I understand that, regardless of my insurance status, I am responsible for this account. I certify that the foregoing information is true and accurate to the best of my knowledge.

_____ _____
Patient or Parent/Legal Guardian signature Date