Dr. Abby Neville

NEVILLE
Dental Care

Patient Information

Today's Date _____

Name _____ Birth Date_____
Address _____ City/State _____ Zip _____
Telephone # Home _____Cell _____Work _____
Email Address _____
Marital Status _____ Social Security # _____
Employed by _____ Occupation _____
Emergency Contact _____ Relationship_____Phone _____

How did you hear about us? _____Referred by _____

Do you have dental insurance? Yes No
If yes:
Name of Policy Holder_____ Relationship _____
Name of Policy Holder's Employer _____
Date of Birth of Policy Holder _____
Policy ID # _____ Group # _____
Name of Dental Insurance Co. _____
Address of Dental Insurance Co. _____
Please list all of the family members covered under this policy _____
_____

I authorize release of any information relating to dental claims. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage on the day of service unless other arrangements have been made prior to the start of treatment. There will be a monthly finance charge of 1.5% (18 % APR) for all balances over 60 days.

Signature of Patient _____ Date _____