	Patient Info	ormation								
Patient Name:		Pref	ferred Name _							
Last □ Male □ Female	First ☐ Married	MI □ Single □ (Child □ Othe	r						
Birth Date:										
Phone (Home):	(Work): Ext:_	(Cell):		(Email):						
Preferred contact method for	or appointment confirmati	on: (Circle 1)	: Home#	Work# Cell#						
Address:					<u> </u>					
Street			Apartment #	<i>‡</i>						
City	State	?	Zip Co	ode	_ 					
<u> </u>										
	Referral Inf	ormation								
Whom may we thank for referrin	g you to our practice? □ Ano	ther patient, frie	end □ Anothe	er patient, relative						
☐ Dental Office ☐ Yellow Pag	es 🗆 Newspaper 🗆 Schoo	ol □ Work □	Internet	ther						
Name of person or office referring	g you to our practice:									
The following is for: ☐ the patient's spo	Spouse or Responsible for p	le Party Info	rmation							
Male □ Female	□Married	□Single □Ch	nild		- -					
Social Security #:		Birth Date:			_					
Phone (Home):	(Work):	Ext:	Best ti	ime to call:	_					
Address:					_					
				Apartment #						
City		State		Zip Code						
	Employment the person responsible for pa									
Employer Name:										
Address: Street	City		State	Zip Code	- 					
	Insurance In	formation								
Primary	insurance in			<u></u>						
Name of Insured:	First	[:	s insured a pa	atient? 🗆 Yes 🗖 No	O					
Insured's Birth Date:										
Insured's Address:		City	State	Zip Code	_					
Insured's Employer Name:					_					
Address:		City	State	Zip Code	_					
	red: 🗆 Self 🗖 Spouse 🗖 Ch									
Insurance Plan Name and Addre	ess:				=					
Secondary					_					
Name of Insured:	First	MI	Is insured a pa	atient? □ Yes □ N	lo					
Insured's Birth Date:			roup #:		_					
Insured's Address:		City	State	Zip Code	_					
insured's Employer Name:		——————————————————————————————————————	Otato	Zip Gode	_					
Address:		City	State	Zip Code	=					
	red: □ Self □ Spouse □ Ch				<u>—</u>					
Insurance Plan Name and Addre	ess:				_					
					DEVON DENTAL ASSOCIATES					

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As a condition of your treatment by this office, financial arrangements must be made in
advance. As a courtesy to our patients, we will process your insurance claim for each
visit and bill you for any remaining balance. Patients who carry dental insurance
should understand that all dental services furnished are charged directly to the patient
and that he or she is ultimately responsible for payment of all dental services. Our
office does not participate with managed dental care insurance plans.

I understand that any fee estimates given for proposed dental treatment can only be honored for a period of twelve months from the date of the patient examination.

I have read the above conditions of payment and treatment and agree to their content.					
Signature of patient, parent or guardian	Date:	Relationship to Patient:			
	Dato:	Polationship to Patient:			

Signature of guarantor of payment/responsible party