# Parkway Dental Care

**Dr. Philip T. Philip**

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Welcome to Parkway Dental Care. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

## Please tell us about yourself

Today's Date: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Date of Birth: _____ Sex: M F

City: _____ State: _____ Zip: _____ Social Security #: _____

Email Address: _____ Do you have dental insurance? Yes No

Who may we thank for referring you to us for care? _____

**If the patient is a minor, please tell us about you, the parent or guardian:**

Your Name: _____ Relationship to Patient: _____

Your Address: _____ Your Home Phone: _____

City: _____ State: _____ Zip: _____ Your Social Security #: _____

## Employer Information

Employer Name: _____ Business Phone: _____

Employer Address: _____ Your Position: _____

City: _____ State: _____ Zip: _____ How long with company? _____

## Spouse Information

Spouse's Name: _____ Spouse's Soc. Sec. #: _____

Spouse's Address: _____ Spouse's Date of Birth: _____

City: _____ State: _____ Zip: _____

Spouse's Employer: _____ Business Phone: _____

How long has your spouse been employed at his/her current company? _____

## Insurance Information

Name of Insurance Co: _____ Plan Name or Number: _____

Name of Insured Person: _____ Group No./Effective Date: _____

Social Security Number of Insured Person: _____ Insured Date of Birth: _____

**AUTHORIZATION for TREATMENT:** This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and Parkway Dental Care, including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Parkway Dental Care, at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

_____ _____

**Patient's (Guardian's) Signature** **Date**