

| PATIENT INFORMATION | | | | | | | |
|--|-----------|--------|----------------------|---|---|---|---|
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Email address: | | | | | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Social Security no.: | | Home phone no.: () | | |
| P.O. box: | City: | State: | ZIP Code: | | Cell Phone No.: () | | |
| Occupation: | Employer: | | | | Employer phone no.: () | | |
| Whom may we thank for referring you to our office? | | | | | | | |

| INSURANCE INFORMATION | | | | | |
|--|--------------------|-------------------------------|---------------------------------|--------------------------------|--------------------------------|
| (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: () | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: () | | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Please indicate primary insurance: | | | | | |
| Subscriber's name: | | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Subscriber ID: |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | Group no.: | Subscriber ID: |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other |

| IN CASE OF EMERGENCY | | | | |
|---|--|--------------------------|------------------------|------------------------|
| Name of local friend or relative (not living at same address): | | Relationship to patient: | Home phone no.: () | Work phone no.: () |
| <p>- The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Walker. I understand that I am financially responsible for any balance. I also authorize Mark E. Walker DDS, PC or my insurance company to release any information required to process my claims. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.</p> <p>- I understand that balances are due upon receipt of statement.</p> <p>- I give permission for Dr. Walker and his clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.</p> <p>- I understand that I may incur a monthly finance charge of 1.5% with a minimum of \$3.00, if the balance of my account remains unpaid by the due date.</p> <p>- I understand that I may be charged a minimum \$25.00 per month late fee for unpaid account balances.</p> <p>- I understand that an appointment cancelled with less than 24 hours notice may be subject to a minimum \$75.00 per appointed hour charge.</p> <p>- I understand that if my account balance is turned over to a collection agency that I am responsible for all collection and attorney fees associated with its collection.</p> | | | | |
| Patient/Guardian signature | | | Date | |