

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	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		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.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> 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.:	Policy no.:	Co-payment: \$
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.:	Policy no.:
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 assign dental benefit payments to be paid directly to Dr. Walker from my insurance company.</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 an 18 % (1.5% monthly) finance charge, minimum \$3.00 monthly, if the balance of my account remains unpaid by the due date (15th of each month).</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