Dr. David D. Mentz **Orthodontist**

Welcome To Our Office

Patient Information

Name_____Nickname_____

Patient Address _____City_____State_____Zip_____

Home Phone_____Date of Birth_____Age_____

Sex _____M_____F School_____Grade_____

Responsible Party Information

Name_____Marital Status_____

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone _____ Work/Cell Phone_____

Previous Address (If less than 3 years)_____
Street City State Zip

Social Security #_____Birthdate_____Relationship to Patient _____

Employer_____Occupation_____No. Years Employed _____

Spouse's Name_____Relationship to Patient_____

Social Security #_____Birthdate_____Work/Cell Phone _____

Employer_____Occupation_____No. Years Employed _____

Dental Insurance Information

Insured's Name_____Insured's Soc.Sec. #_____

Insurance Company_____Group #_____Phone #_____

Insurance Company Address_____

Do you have dual coverage_____Yes_____No If yes:

Insured's Name_____Insured's Soc.Sec. #_____

Insurance Company_____Group #_____Phone #_____

Insurance Company Address_____

Insured's Employer_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____Date_____