David A. Page, DDS

Michael S. Page, DDS

Page Family Dentistry

-SOMETHING TO SMILE ABOUT-

***Patient Information**

Name _____ Birthdate _____

Address _____ City _____

State _____ Zip Code _____ Social Security Number _____

Home Phone _____ Cell Phone _____

Email _____

***Responsible Party (Billing Party)**

Name of Person Responsible for this Account _____

Relationship to Patient _____ Birthdate of Subscriber _____ Work Phone _____

Address of Responsible Party _____

Employer _____ Work Phone _____

***Dental Insurance Information**

Name of Subscriber _____ Birthdate of Subscriber _____

Relationship to Patient _____ Social Security # _____ Work Phone _____

Insurance Company _____ Address _____

Insurance Identification Number _____ Group Number _____

***Secondary Insurance Information** (if any)

Name of Subscriber _____ Birthdate of Subscriber _____

Relationship to Patient _____ Social Security # _____ Work Phone _____

Insurance Company _____ Address _____

Insurance Identification Number _____ Group Number _____

Previous Dentist Information:

Office Name _____ Date of last dental visit _____ Were X-rays taken? Y / N

***Emergency Contact:** Name: _____ Phone Number: _____

I have received a Notice of Privacy Practices from Page Family Dentistry.
I have read, understand and agree to the terms of the financial agreement presented to me.
*Please do not sign this form until you read and understand the Notice of Privacy Practices and our financial agreement, even if you are advised otherwise. You are entitled to an exact copy of any agreement you sign.

Signature _____ Date _____

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