Acct # _____ Date _____

PATIENT INFORMATION RECORD

Patient's Name _____
Last First MI

Mailing Address _____
Street City State Zip

Home Phone (____)_____ Business Phone (____)_____ Ext._____ Cell (____)_____

Sex _____Date of Birth_____ Social Security # _____

Employer _____E-mail

_____

Address _____
Street City State Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____Social Security # _____
Last First MI

Spouse's Employer _____

Address _____ Work Phone (____)_____

Referring Dentist (if applicable) _____

GUARANTOR (Person Responsible for Bill)

Name of Guarantor _____ Relationship _____

HOW DO YOU PLAN TO PAY FOR TODAY'S VISIT? ☐ Cash ☐ Check ☐ Credit Card

IN CASE OF EMERGENCY, please state name of nearest relative/friend: _____

Phone (____)_____ Cell (____)_____

PLEASE COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS A MINOR OR STUDENT:

Responsible Parent's
Name _____ Business Phone (____)_____

Responsible Parent's
Employer _____ Social Security # _____

PRIMARY DENTAL INSURANCE COMPANY NAME _____ Group # _____

Address _____ Phone # (____)_____

Name of Policy Holder _____ D.O.B. _____

Social Security # _____ Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer _____

SECONDARY DENTAL INSURANCE COMPANY NAME _____ Group # _____

Address _____ Phone # (____)_____

Name of Policy Holder _____ D.O.B. _____

Social Security # _____ Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer _____

Kelly Wilkes Ford, D.M.D., M.H.S., PA

Practice Limited to Periodontics

321 North Laurel Street
Summerville, South Carolina 29483
Telephone: 843-871-6636

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of by knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____

Patient or Responsible Party

I give permission to Kelly Wilkes Ford, D.M.D., M.H.S., P.A. its members and employees to share my information with:

_____

_____

so that this person or entity may assist me with my health care issues. In addition, I ____ DO ____ DO NOT allow permission for messages to be left on my contact numbers.

PAYMENT DEFAULT

In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

X _____

Patient or Responsible Party