DOUGLAS BECKHAM D.M.D., P.C.

Today's Date_____

PATIENT INFORMATION

Patient's Last Name	First Name	Initial	Age	Sex	Date of Birth

Home Address	City	State	Zip Code	Home Phone Number

Employer Name and Address:	Occupation	Phone Numbers Work Cell	Social Security Number

Who referred you to this office?	If Minor, Name of School	Drivers License Number

Marital Status	Spouse Name	Spouse Work Number	Children's Names and Ages

Spouse Employed By:	Occupation	Spouse Cell Number

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account			
Home Address (if different from Patient	City	State	Zip Code

Home Phone Number	Social Security Number	Drivers License Number

How would you like to pay for today's visit?

CASH_____ CHECK_____CREDIT CARD_____

INSURANCE INFORMATION

Do You Have Dental Insurance?	
Name of Insured	Date of Birth
Name/Address of Primary Dental Insurance	Policy Number/Group Number
Name/Address of Secondary Dental Insurance	Policy Number/Group Number

OFFICE POLICIES

EMERGENCIES: All emergency services to be paid in cash.

APPOINTMENTS: A minimum charge will be made for broken or cancelled confirmed appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

DELINQUENT ACCOUNTS: I do hereby agree that payment is due when services are rendered, unless other payment arrangements have been made. Should my account become delinquent and require the services of an attorney or a collection agency for collection, I will pay all collection fees and/or a reasonable attorney's fee, as well as all court costs, which will be added to the original amount of the delinquent account. I also waive rights of exemption under the constitution and laws of Alabama or any other state as to personal property. All accounts over 60 days will be charged 1.5% interest. All accounts must be paid in 90 days to avoid collection procedures UNLESS FINANCIAL ARRANGEMENTS ARE MADE PRIOR TO TREATMENT.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

Signature:_____**Date:**_____

(Parent or Guardian, if patient is a minor)

Patient Information (New Patient Information) Rev: 3/2//07