Patient Information Form

Name _____S.S.N. _____Date of Birth_____
Home Address _____ City _____ State_____ Zip _____
Mailing Address _____ City _____State _____ Zip _____
Home Phone _____ Cell Phone _____ Email Address _____
How would you like for us to contact you: Text, Mail, Phone, Email
Place of Employment _____ Work Phone _____
Address _____ City _____State _____ Zip_____
Name of Spouse _____ Spouse Date of Birth _____
Place of Employment _____ Work Phone _____
Whom may we contact in case of emergency _____
Relationship to you _____ Home Phone _____
Work Phone _____ Cell Phone _____
Nearest relative not living with you _____Phone _____
Nearest friend not living with you _____ Phone _____
How did you hear about our office? ____ Friend ____Website _____ Post card ___ Internet ____ Other
Physician _____ Phone _____
Last Dentist _____ Phone _____

Responsible Party

Who is responsible for this bill _____
Relationship to patient _____ Home Phone _____
Address _____ Cell Phone _____
Driver's License Number _____ State _____ Date of Birth _____
Financial Institution _____ S.S.N._____
Name of Employer _____ Phone _____
Employer Address _____
Is this person currently a patient in our office? _____ Yes _____ No
I will be paying today by: _____ Cash _____ Check _____ Credit Card

Insurance Information

Name of Insured _____ Home Phone _____
Date of Birth _____ S.S.N. _____ Date Employed _____
Name of Employer _____
Address of Employer _____ Work Phone _____
Insurance Company _____ Group Number _____
Insurance Address _____Policy ID Number _____

I understand and agree that payment for service is due at the time of treatment. I agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any services rendered by Dr. James Holman. If I have insurance, the percentage of the bill not covered by insurance is due at the time of service. I understand that there will a 1 ½ % service charge per month (18% APR) add to my overdue *accounts, and that I am responsible for all legal fees and collection fees. (*accounts are considered overdue 30 days past due) I have read all the information on both sides of this sheet and have completed all the answers. I certify that information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature _____ Date _____
If patient is a minor, please have parent sign.