JOHN E. SMITH, D.M.D.
MICHAEL J. WELCH, D.D.S.
38 S LAST CHANCE GULCH, HELENA, MONTANA 59601 (406)443-6160

PERSONAL

Patient's Name _____Social Security Number _____

( )Child ( ) Unmarried ( ) Married ( ) Separated ( ) Widowed ( ) _____ Sex M F

E-mail address _____ Date of Birth _____

Address _____Home Phone _____

Number and Street City State Zip Cell phone_____

Patient's Employer _____Occupation _____

Business Address _____Phone _____

Parent's or Spouse's Name _____Social Security Number _____

Parent's or Spouse's Employer _____

RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY

Name _____Phone _____

Address _____

Is there anything that we can do to make your first visit more comfortable for you?

_____

Whom may we thank for referring you to our office?_____

INSURANCE INFORMATION

Insurance _____Effective Date_____

Name of Insurance Plan

Subscriber Name _____Relationship to Subscriber_____

Policy or Certificate number _____Group Number _____

PAYMENT OF DENTAL FEES

I AUTHORIZE TREATMENT OF THE PATIENT NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT WHEN SERVICES ARE RENDERED UNLESS CREDIT ARRANGEMENTS ARE AGREED UPON IN ADVANCE IN WRITING.

I/We agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

DATE_____RESPONSIBLE PERSON_____