MESA DENTAL GROUP

It is customary to pay for service when rendered.
Unless prior arrangements have been made.
****There will be a $50.00 fee for any returned check****

PATIENT HISTORY INFORMATION

Patient's Name: _____ Birthdate: _____ Sex _____ Marital Status: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Social Security No. _____ Driver's License No. _____

Employer: _____ Occupation _____

Employer's Address: _____ City _____ Zip Code _____

Has any family member been a patient before? _____ If yes, their name _____

How did you hear about us? _____ Referrals are appreciated and welcome!

In case of an emergency please contact _____ Relationship _____

Address _____ City _____ Phone Number _____

INSURANCE INFORMATION

1ST Insurance

Subscriber's Name _____ Relationship _____ Birthdate _____

Social Security No. _____ Employer _____

Insurance Co. Name _____ Group Name/ No. _____

2nd Insurance

Subscriber's Name _____ Relationship _____ Birthdate _____

Social Security No. _____ Employer _____

Insurance Co. Name _____ Group Name/ No. _____

If no Insurance Name of person responsible for bill

Address _____ City _____ Zip Code _____

Home/Cell Phone _____ Work Phone _____