WELCOME

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we will be glad to help (please print)

Mark R. Doherty D.D.S. P.C. * Pryor Dental Center * 1909 S. Elliott, Pryor, OK 74361 * (918) 825-0941
pryordentalcenter.com

Patient Name: _____ DOB: __/___/___
FIRST MI LAST

Patient SSN: _____ Male { } Female { }
Address: _____ City: _____ State: ____ Zip: _____
Home #: _____ Cell #:_____Work #:_____
Employer: _____ Occupation: _____
Are You: Minor { } Married { } Single { } Divorced { } Widowed { } Separated { }

RESPONSIBLE PARTY ***(If different than patient)***

Name: _____ DOB: __/___/___
FIRST MI LAST
SSN: _____ Male { } Female { }
Address: _____ City: _____ State: ____ Zip: _____
Home #: _____ Cell #:_____Work #:_____
Employer: _____ Occupation: _____
Relationship to patient: _____

DENTAL INSURANCE

Subscriber Name: _____ DOB: ___/___/___
FIRST MI LAST
SSN: _____ Male { } Female { }
Address: _____City: _____ State: ____ Zip: _____
Policy #: _____ Group #:_____Ins. Company: _____
Employer: _____ Occupation: _____ Work #:_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? Yes { } No { } if yes complete the following:

Subscriber Name: _____ DOB: ___/___/___
FIRST MI LAST
SSN: _____ Male { } Female { }
Address: _____City: _____ State: ____ Zip: _____
Policy #: _____ Group #:_____ Ins. Company: _____
Employer: _____ Occupation: _____ Work #:_____

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees for services rendered to myself or child. I accept full financial responsibility for all charges not covered by insurance. I understand that the office will file my insurance as a courtesy to me and that there is no guarantee of payment or eligibility. I understand the office is not responsible for knowing my dental policy. I am assigning directly to Pryor Dental Center all benefits, if any, payable to me for services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic. In the event my account is placed for collection, it will be subject to an additional 40% charge, along with any additional court costs and attorney fees incurred.

A 24 hour notice to cancel or change an appointment is mandatory. Failure to give notice may result in charges or appointment deposits.

As a parent or guardian, you are authorizing the dental staff to perform necessary dental services for your child, including but not limited to x-rays, and administration of anesthetic which are deemed advisable by the doctor, whether you are present when the treatment is rendered.

A parent or guardian is required to be present for all appointments for children under 18.

Patient or Responsible Party Signature: _____ Date: _____