

FRANK T. CURRY, D.D.S., INC.

ABOUT YOU

Today's Date: _____

Name: (LAST) _____

Mr. Mrs. Ms. Dr. (FIRST) _____ (M.I.) _____

I prefer to be called: _____

Birthdate: _____ Female Male

SS#: _____ DL#: _____

Home Address: _____
_____ Single Married Other

Hm#:() _____ Other#:() _____

Wk#:() _____ Ext: _____ Pgr:() _____

Fax#:() _____ E-mail: _____

Employer: _____Employer's Address: _____

How long there? _____ Occupation: _____

If Minor, Name of School: _____

Where & when are the best times to reach you?

Other family members seen by us: _____

Previous/Present Dentist: _____
(Please circle)

Phone#:() _____ Last Visit Date: _____

Whom may we thank for referring you?

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Wk#:() _____ Ext: _____ DOB: _____

SS#: _____ DL#: _____

Neighbor or Relative not living with you.

His/Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

Address: _____

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Insurance Co. Phone#: _____

Group #: (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

Insured's Address: _____
_____**Secondary Dental Insurance**

Insurance Co. Name: _____

Address: _____

Insurance Co. Phone #: _____

Group #: (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS#: _____

Insured's Employer: _____

Person Responsible for Account: _____

Wk#:() _____ Ext: _____ Hm#: _____

Billing Address: _____

Relationship: _____

Employer: _____

SS#: _____ DL#: _____

FINANCIAL

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If the office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____

Date _____