PATIENT INFORMATION

Patient Name

First Name: _____ Last Name: _____

Contact Information

Address: _____

Apt. #: _____City: _____ State: _____ ZIP: _____

Date of Birth: _____ Social Security No.: _____

Primary Phone: (_____) -_____

Text Messaging Consent: ☐ Yes ☐ No (See Attached Consent form)

Other Phone: (_____) -_____

Email Address: _____

Email Messaging Consent: ☐ Yes ☐ No (See Attached Consent Form)

May we leave confidential voicemail messages at any of the phone numbers listed above?

☐ Yes ☐ No

If yes, please specify: ☐ Primary Phone ☐ Other Phone

How did you hear about our office? _____

Employment Information

Employer Name: _____

City/State: _____ Work Phone: _____

RESPONSIBLE PARTY

Complete this section if someone other than the patient is financially responsible.

First Name: _____ Last Name: _____

Address: _____

Apt. #: _____ City: _____ State: _____ ZIP: _____

Phone: (_____) -_____

Date of Birth: _____ Social Security No.: _____

Relationship to Patient: _____

EMERGENCY CONTACT & PHYSICIAN

Emergency Contact

Full Name: _____

Phone: (_____) -_____

Primary Physician

Physician Name: _____

Phone: (_____) -_____

DENTAL INSURANCE INFORMATION

Please provide your current dental insurance card.

Policyholder Name: _____

Policyholder Date of Birth: _____

Address (if different from patients): _____

Apt. #: _____ City: _____ State: _____

ZIP: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policyholder Social Security No. or Subscriber ID: _____

Group Number: _____

Policyholder's Employer: _____

Insurance Company Name: _____

Claims Mailing Address: _____

City: _____ State: _____ ZIP: _____

IMPORTANT INFORMATION & ACKNOWLEDGMENTS

Please read each statement and initial on the line provided.

I consent to examinations, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by Dr. McClung and/or his designated providers.

Initials: _____

I authorize the release of medical information necessary for treatment and to determine benefits payable for insurance claims related to services rendered. Where applicable, I assign insurance benefits payable for these services to this office.

Initials: _____

I understand that I am financially responsible for all charges incurred, whether or not they are paid by my insurance company.

Initials: _____

I understand that if I default on payment of my account and collection agency services are required, collection costs may be added to my account balance, including attorney and court costs, as permitted by applicable law and any applicable agreement.

Initials: _____

Patient or Legal Guardian Signature: _____

Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____