KEVIN L. MARVIN
DMD

PATIENT INFORMATION

Date ____________________

Name ____________________ Sex: M ____ F ____ Birthdate ____/____/____

Social Security # ____________________ Home Phone ____________________ Cell Phone ____________________

Address ____________________ City ____________________ State ______ Zip ____________

Email ____________________ Driver License # ____________________

When confirming appointments how do you prefer to be contacted? ____Phone ____Email ____Text Message

Patient or Parent Employer ____________________ Work Phone ____________________

May we contact you at work? ________ Marital Status: Single ________ Married ________ Divorced ________ Widowed ________

In case of emergency who should be notified? ____________________ Phone ____________________

How did you hear about our office? (Check all that apply)

____Google ____Website ____Yellow Pages ____Drive By ____Insurance Listing ____Other

Friend ____________________ Patient ____________________

PRIMARY INSURANCE

Person Responsible for Account ____________________ Relation to Patient ____________________

Employer ____________________ Birthdate ______________ Soc. Sec. # ____________________

Address (if different from patient ' s) ____________________ Phone ____________________

City ____________________ State ______________ Zip ____________________

Insurance Company ____________________

Contract # ____________________ Group # ______________ Subscriber # ____________________

Name of other dependents covered under this plan ____________________

DENTAL HISTORY

Name of Previous Dentist/Location ____________________ Date of Last Exam/Cleaning ______________

What would you like to change about your smile? ____________________

OFFICE POLICIES

I understand that payment is expected at time services are rendered. If I have dental insurance, I authorize payment directly to the doctor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that deductibles and copays are due on the date of service. The office does its best to give me the most accurate estimate of my benefits. I know that insurance companies do not guarantee benefits over the telephone. I understand that I am responsible for knowing the coverage and benefits of my insurance policy. If my insurance company does not pay my claim as expected, I understand that the responsible party is obligated for the balance of the account. I understand that if my account must get turned over to a collection agency that I am responsible for a $30.00 late fee.

Signature of Patient or Parent if Minor ____________________ Date ______________