

Steven M. III
SOUTHWOOD
Jerry M. Brian J. III
PAUL POPE
FAMILY DENTISTRY
PATIENT INFORMATION

PERSONAL INFORMATION:

Name: _____ Birth Date: _____ Address: _____
 City: _____ State: _____ Zip: _____ SS# _____
 Telephone: (Home) _____ (Work) _____ (If Child) _____
 (Parents Names) _____
 Spouse Name: _____ SS# _____ Birth Date: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship: _____ SS# _____
 Address: _____ Telephone #: _____
 City: _____ State: _____ Zip: _____

HEALTH INFORMATION:

Personal Physician Name: _____ Telephone # _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD:

- | | | |
|-------------------|---------------------|-----------------------|
| Artificial Joints | Epilepsy | Kidney Trouble |
| Asthma | Heart Murmur | Mitral Valve Prolapse |
| Cancer | Hepatitis | Rheumatic Fever |
| Cold Sore | High Blood Pressure | Stroke |
| Diabetes | HIV | Other Diseases |

If you circled any above please describe conditions: _____
 Please list any medications you may be taking: _____
 Who referred you to our office? _____
 Please list any allergies: _____ If female, are you pregnant? _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Co.: _____ Employee: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ SS# _____ Group # _____
 Secondary Ins. Co.: _____ Employee: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ SS# _____ Group #: _____

I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD PARTY INVOLVEMENT. I UNDERSTAND THAT MY ACCOUNT IS TO BE PAID IN FULL WITHIN 90 DAYS OF THE DATE OF SERVICE UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE: _____ **DATE:** _____