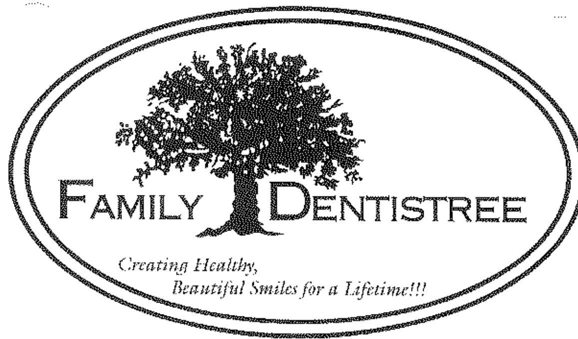
JOHN C. HALL, D.D.S.
S. LANCE WEST, D.D.S.



JAMES R. MILLER, D.M.D.
ANTHONY J. LEONARDS, D.M.D.

Welcome To Our Office

PLEASE READ AND COMPLETE ALL SECTIONS OF THIS INFORMATION FORM

NAME: ______________________ HOME PHONE: ____________ WORK PHONE: ____________ CELL PHONE: ____________

HOME ADDRESS: ______________________ CITY/STATE: ______________ ZIP: ____________

S.S.# ________________ MARITAL STATUS S____ M ___ W____ D____ DATE OF BIRTH ______________ SEX M ____ F____

I WAS REFERRED BY: ______________________________ EMAIL ADDRESS: ________________

I HEARD ABOUT YOU FROM: (CHECK ONE)

_____ YELLOW PAGES
_____ SIGN
_____ WEBSITE
_____ TELEVISION COMMERCIAL

_____ OTHER (PLEASE EXPLAIN)
____
____

EMPLOYER'S NAME: ______________________ WORK ADDRESS: ______________________

SPOUSE'S NAME: ______________________ S.S.# ______________________

SPOUSE'S EMPLOYER: ______________________ ADDRESS: ______________________

DENTAL INSURANCE: ______________________ GROUP #: ______________________

____ FAMILY ___SELF PERSON CARRYING INSURANCE (SELF) ________ (SPOUSE) ________

Our goal is to provide the finest, most effective health care treatment available today. Following your diagnosis, the doctor will advise you of their plan for treatment. Additionally, we will discuss with you the cost of today's and further treatment.

Payment for today's visit and your future visits is due at the time of treatment. We are sensitive to the fact that some patients may not be able to pay cash for their treatment, therefore, we do offer several alternative payment programs for your convenience.

HOW DO YOU WISH TO PAY TODAY?

(Check one) _____ CASH _____CHECK _____CREDIT CARD _____ DEBIT _____CARE CREDIT

I understand and agree that, regardless of my insurance status, all deductible and co-payment charges are due at time of service. **This office files my primary insurance as a courtesy to me. I am financially responsible for my bill.** I have read all the information on this form and have completed the above information as true and correct to the best of my knowledge. Further, I authorize the release of any dental or other information necessary to process my dental claims.

X ______________________________ Date: ______________

Signature of Patient or Responsible Party