ROGERSVILLE
FAMILY DENTISTRY

Gentle, high-tech care right here at home

Welcome

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number_____

Name_____ Date_____
Soc. Sec. #_____ Birthdate _____ Home PH_____
Address_____ City_____ Cell PH _____
State _____ Zip_____ Email _____
Circle Appropriate: Minor Single Married Divorced Widowed Separated
If Student, Name of School/ College _____ ___ Full Time ___ Part Time
Patient's or Parent's Employer _____ Work Phone _____
Business Address_____ City _____ State _____ Zip_____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Have you seen our web site? Yes_____ or No_____
Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency_____Phone_____

Responsible Party

Name of Person Responsible For This Account _____Relationship_____
Address _____ City _____State_____ Zip_____
Drivers License # _____ Birth date _____Financial Institution _____
Employer _____ Work Phone _____ SS#_____
Is This Person Currently a Patient in Our Office ___ yes ___no

Insurance Information

Name of Insured_____ Relationship to Patient _____
Birth date _____ SS# _____Date employed _____
Name of Employer _____Work Phone _____
Insurance Company _____Group # _____ Policy ID#_____

Do You Have Additional Insurance? ___ Yes ___No If yes complete the following.
Name of Insured _____Relation to Patient _____
Name of employer _____Work Phone _____
Employer Address _____ City _____ State _____Zip _____
Insurance company _____ Group# _____ Policy ID _____

By signing below I give permission for Dr. Timothy Gunnin to use photographs he may take of my teeth for research and publication in professional journals.

In addition, I authorize Rogersville Family Dentistry to use my Protected Health Information to obtain benefits and payment from my insurance company. I further understand my dental benefit plan is an agreement between myself and my insurance company and I am ultimately responsible for all fees insurance does not pay.

_____ _____
Signature of Patient or legal guardian Date

_____
Relationship to patient

For your convenience, we offer the following methods of pmt: Cash, Check, Visa, MC, Disc, Am Ex.
Payment is due when services are rendered
WE REQUIRE 48 HOURS NOTICE WHEN CANCELLING AN APPOINTMENT