

Smiles..... the ultimate accessory

Jess N. Legg, III, DDS

HELP US TO GET TO KNOW YOU BETTER! CONFIDENTIAL PERSONAL INFORMATION

Date: _____

Patient Name: _____ SS# _____

Drivers Lic. # _____

Address: _____

Street City State Zip

Telephone: Home: _____ Business: _____

Cell: _____ E-Mail: _____

Birthdate: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Employer: _____ Referred By: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is another member of your family a patient at our office? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____

Address: _____

Street City State Zip

Telephone: Home: _____ Business _____

DENTAL INSURANCE INFORMATION

Insurance Company: _____

Address City/ State/ Zip

Employee: _____ Relationship: _____ SS#: _____ Date of Birth: _____

Employer: _____ Policy/Group #: _____

I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR ANY OTHER THIRD PARTY INVOLVEMENT. I AGREE TO PAY 1.5% FINANCE CHARGE PER MONTH ON ANY OOUTSTANDING AMOUNTS OVER 60 DAYS.

Signature: _____ **Date:** _____