

ROBERT A. WALKER, D.D.S.

Date _____

PATIENT INFORMATION

Name _____

Nickname _____

Male _____ Female _____

Marital Status _____

DOB ____ / ____ / ____ SS# _____

Home Address _____

City _____ St _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email (Optional) _____

Patient's Employer _____

Occupation _____

How did you hear about our office? If referred, whom may we thank?

Please list other family members seen by us

Permission for treatment - I hereby grant permission to Dr. Walker and Staff to recommend and complete treatments and therapy as deemed necessary.

The information I have given today is true to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

Financial Agreement - All charges for services and treatment will be paid upon completion of appointment, unless other arrangements have been made. Outstanding balances shall accrue interest monthly.

If insurance is involved - I hereby authorize payment directly to Dr. Walker of Group Insurance Benefits otherwise payable to me.

Broken Appointments - I understand that appointments changed without 24 hours notice may be assessed a broken appointment charge of \$50/hour.

Patient, Guardian, or Guarantor's Signature

BILLING INFORMATION

(Complete this only if billing information is different from patient information section)

Person Responsible for Account or Insured

Relationship to Patient _____

Billing Address _____

City _____ St _____ Zip _____

Home Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's Name _____

DOB ____ / ____ / ____

Employer _____

Dental Insurance _____

Suscribers S.S.# or ID# _____

Group # _____

Claim Mailing Address _____

City _____ St _____ Zip _____

Relationship to Patient _____

SECONDARY INSURANCE

Subscriber's Name _____

DOB ____ / ____ / ____

Employer _____

Dental Insurance _____

Suscribers S.S.# or ID# _____

Group # _____

Claim Mailing Address _____

City _____ St _____ Zip _____

Relationship to Patient _____

EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone _____

Work Phone _____