Eastern Shore DENTAL CARE
BILLINGS • MURPHY

PATIENT INFORMATION

Patient's Name:_____
First **Middle** **Last** **Preferred Name**

Address:_____City:_____State:_____Zip Code:_____
Home Phone:_____Cell Phone:_____Text Messages OK?_____
E-mail Address: _____Work Phone:_____Ext :_____
Sex: [ ] MALE [ ] FEMALE [ ]Minor [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Separated
Birthdate:_____ Age:_____ Social Security #: _____

Who can we thank with a Gift Card for referring you? _____
Or, please circle one of the following referral sources:

The Shore Update TV The Bay Times/Record Observer Facebook Online/ Website
Radio Charitable Organizations What's Up! Magazine Insurance Location

Local Event_____ Other_____

RESPONSIBLE PARTY

Name of person responsible for this account: _____
Relationship to patient: _____
Address:_____City:_____State:_____Zip Code:_____
Home Phone:_____ Cell Phone:_____Text Messages OK?_____
E-mail Address: _____Work Phone:_____Ext :_____
Drivers License #:_____Soc.Sec.#_____Birthdate:_____
Employed by:_____Work Phone: _____Ext :_____

INSURANCE INFORMATION

Name of insured: _____Relationship to patient: _____
Birthdate:_____Soc.Sec.#:_____
Name of Employer:_____ Union/Local#:_____
Address:_____City:_____State:_____Zip Code:_____
Insurance Company:_____Phone #:_____Group/Policy ID:_____
Address:_____City:_____State:_____Zip Code:_____

SECONDARY INSURANCE INFORMATION

Name of insured: _____Relationship to patient: _____
Birthdate:_____Soc.Sec.#:_____
Name of Employer:_____ Union/Local#:_____
Address:_____City:_____State:_____Zip Code:_____
Insurance Company:_____Phone #:_____Group/Policy ID:_____
Address:_____City:_____State:_____Zip Code:_____

Collection Policy & Agreement :**When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorneys fee may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, finance charges, reasonable collection agency fees, attorney's fees, and court costs. Such fee represents administrative, accounting, bookkeeping, account maintenance, legal and management fees associated with delinquent accounts.**

Patient/Parent Guardian (Minors) Signature: _____ Date: _____

Patient's Name Printed: _____