



Scott J. Crews D.D.S.

Complete Family Dentistry

This form will be used as part of your permanent records. Please make this information as complete as possible so that we may render you the best possible service. All records will be kept confidential.

Date _____

Patient Name _____ Soc. Sec. No. _____
Last First and Middle

Home Address _____ Phone No. _____

City _____ State _____ Zip _____ Bus. Phone _____

Date of Birth _____ Age _____ Marital Status S M D W (circle one)

Occupation _____ Employer _____

Spouse or Father Name _____ Birthdate _____ Soc. Sec. No. _____

Occupation _____ Employer _____ Bus. Phone _____

If child: Mother Name: _____ Birthdate _____ Soc. Sec. No. _____

Occupation _____ Employer _____ Bus. Phone _____

Person Financially Responsible for Account _____		Relationship to Patient _____	
Billing address if different from above _____		Soc. Sec. No. _____	
Occupation _____	Employer Name and Address _____	How Long Employed _____	
PRIMARY INSURANCE		SECONDARY INSURANCE	
Subscriber: _____	SS# _____	Subscriber: _____	SS# _____
Insurance Co. Name & Address _____	Employer _____	Insurance Co. Name & Address _____	Employer _____
Group # _____	Birthdate _____	Group # _____	Birthdate _____

Whom may we thank for this referral? _____

Name of Physician _____ Phone _____

- (1) I authorize the Doctor to perform all forms of treatment, medication and therapy that may be indicated for (my) (my child's) dental treatment.
- (2) I understand that I am financially responsible for all fees regardless of any dental coverage I may have.
- (3) Unless otherwise stipulated I hereby authorize group insurance benefit payments to the above named dentist.

Signature _____ Date _____

Notes: _____

THE FEE FOR EMERGENCY CARE REQUIRING ONLY A SINGLE VISIT IS PAYABLE AT TIME OF SERVICE.