JACOB GRAPEVINE DDS
SIGNATURE DENTISTRY

Patient Information

Patient Name:_____ Date:_____

Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date:_____

Social Security #:_____ Drivers License # _____ State:_____

Address _____
Street Apartment #

_____
City State Zip Code

Phone (Home):_____ (Work):_____ Ext:_____ Email:_____

Cell:_____ Cell Phone Carrier:_____

Best time to call _____ Best way to contact you: _____ If Cell, may we text you _____

Referred by: _____

Responsible Party Information

(Please Complete even if patient)

Name*_____

Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #:_____ Birth Date: _____ Drivers License # _____

Phone (Home):_____ (Work):_____ (Cell):_____ Best time to call: _____

Address _____
Street Apartment #

_____
City State Zip Code

Signature of Patient, Parent or Guardian _____

- Financial responsibility lies with the patient, guardian, or parent who brings a child that receives treatment. We do not accept the responsibility for billing another parent or former spouse. Please be prepared to handle financial matters at the time of your child's or dependent's visit.

Insured and Employment information

(if applicable)

Employer Name: _____Occupation: _____

Address:_____

Insured Name _____ Insured Birthdate _____

Insurance Co. Name _____ Ins. Co. Phone # _____

Subscribers ID or SS# _____ Group # _____

Claims Address _____

Payment for treatment is due upon service. We will automatically file your insurance for you and payment will be sent to you directly. See financial arrangement sheet for more information.

Release of info (please sign) _____Date _____