WELCOME TO OUR PRACTICE

GREGORY D. MARTIN D.D.S.

WHOM MAY WE THANK FOR REFERRING YOU:______________________

PATIENTS FULL NAME____
FIRST MI LAST

MALE __ FEMALE___MINOR___ SINGLE___MARRIED____ OTHER_______
FULL TIME STUDENT?______SCHOOL_____________________________

CURRENT ADDRESS:____

____
CITY STATE ZIP

PHONE: HOME_______________CELL_____________WORK_____________

EMAIL_____________________CAN WE CONTACT YOU BY EMAIL?________

BIRTHDATE_______________SS#_____________ ___DL#________________

PERSON RESPONSIBLE FOR ACCOUNT?______________________________

EMPLOYER:____________________________________HOW LONG?_______

EMPLOYERS ADDRESS:____

EMPLOYERS PHONE:________________POSITION?____________________

INSURANCE INFORMATION: (Please present Card)

PRIMARY DENTAL INSURANCE:_____________________________________

ADDRESS______________________________________PHONE____________

INSUREDS NAME:______________ID#_________________BIRTHDATE_____
RELATION:__________________EMPLOYER:__________________________

SECONDARY INSURANCE:____

I Certify that I and/or my dependents have insurance coverage and hereby assign directly to Dr Gregory Martin all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that a finance charge will be added to accounts over 90 days.

SIGNATURE________________________________DATE_______________