El Paso Quality Dentistry, P.A.

WELCOME TO OUR PRACTICE

Name _____
Last Name First Name Initial

Address _____
City State Zip

Cell #_____ Work #_____ Home #_____

E-Mail:_____ Soc. Security #_____

Sex: M F Birthdate_____ Spouse's Name_____

Patient Employed by _____

In case of emergency who should be notified? _____

Phone / Contact info_____ Relation to Patient_____

Whom may we thank for referring you _____

Person Responsible for Account

Person Responsible for Account _____
Last Name First Name

Relation to Patient_____ Birthdate_____ Phone # _____

Address_____ SS#_____
City State Zip

Dental Insurance

Company Name: _____ Phone #_____ Group # _____

Address_____ ID# _____
City State Zip

Name of Subscriber _____ Birthdate _____SS#_____

As a courtesy to you, our office will process your **primary insurance** and will submit requested information on your behalf. **Full Payment or Estimated Portion is due at time of treatment**, unless prior written arrangements have been made by our office Administrator. A Balance on your account after 90 days of insurance processing, becomes your responsibility. It is also your responsibility to remit payment for services not covered by your insurance.

Signature_____ Print Name _____Date_____