Welcome to our office! Please fill out this form completely.

Date:__________________

Patient's name____Birth date_____________ Sex M/F
Last First MI
Patient's Social Security #___________________________ Name Patient prefers_________________
Hobbies/Pets___________________________________ Grade___________________________
Names(s) and age(s) of siblings in family____
Do parents' live together?_____yes _____no If not, with whom does the child reside?______________

Parent or Guardian Information ____ Mother _____Stepmother ____Guardian
Name____________________________ DOB___________ Occupation__________________
Address__________________________ City___________ State_____ Zip_____________
Employer_________________________ Work#_______________________________________
SS#_________________ Home #_____________ Cell #____________________________
Martial Status_______________E-Mail Address___________________________________

Parent or Guardian Information ____ Father _____Stepfather ____Guardian
Name____________________________ DOB___________ Occupation__________________
Address__________________________ City___________ State_____ Zip_____________
Employer_________________________ Work#_______________________________________
SS#_________________ Home #_____________ Cell #____________________________
Martial Status_______________E-Mail Address___________________________________

How did you find out about our office?____
Who is your family dentist?____________________________Phone #___________________

Method of Payment
___Check or cash at time of payment ____Bank Card ____Visa ____ Master Card
___Insurance-Plus co-payment at time of treatment
___South Carolina Medicaid#______________________

Primary Dental Insurance
Insured's Name____________________
Relationship______________________
Birth date________________________
Social Security #___________________
Employer_________________________
Insurance Company________________
Group#____________Policy#_______
Insurance Company Phone#__________

Secondary Dental Insurance
Insured's Name____________________
Relationship______________________
Birth date________________________
Social Security #___________________
Employer_________________________
Insurance Company________________
Group#____________Policy#_______
Insurance Company Phone#__________

Financial Policy
Fees for dental services rendered are due at the time of treatment. Our office, as a courtesy to you, will file your insurance for treatment rendered. You will be responsible for deductibles, and all balances not covered by your insurance. There will be a $30.00 charge for all returned checks.

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Lexington, SC 29072
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F: 803.359.7542

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