Mark L. Worthington DMD, PC
COSMETIC AND COMPREHENSIVE DENTISTRY

Date: _____

PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home #: _____ Work #: _____

Birthdate: ___/___/___ Age: _____ SS# _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home #: _____ Work #: _____

Birthdate: ___/___/___ Age: _____ SS#: _____

Employer & Address: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Birthdate: _____

ID#: _____

Employer: _____ Group#: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

SECONDARY INSURANCE:

Policy Holder Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Birthdate: _____

ID#: _____

Employer: _____ Group#: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

In the Event of an Emergency:

Who should we contact: _____

Relation: _____

WK #: _____ HM #: _____

Physician Name: _____

Phone #: _____ Last Visit: _____

Please note: Payment in full is expected at the time of service. If you are covered by insurance, we are happy to file claims and assist you with dealing with your insurance, however, the full fee for treatment is your responsibility.

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance for myself and dependents at the time of service unless financial arrangements have been made.

Signature: _____

Phone (541) 484-9262
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