Matthew B. Brown, DDS, MD **Paul S. Chahal, DDS** **John T. Bowman, DMD, MD**

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PATIENT INFORMATION

PREFIX FIRST NAME MI LAST NAME SUFFIX	NAME I LIKE TO BE CALLED	SEX M _____ F_____
STREET ADDRESS	DATE OF BIRTH	HOME PHONE NUMBER
CITY, STATE, ZIP CODE	CELL PHONE NUMBER	
EMPLOYER (IF STUDENT, NAME OF SCHOOL)	EMAIL ADDRESS	
REFERRED BY	NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY	
PHARMACY NAME AND LOCATION	RELATIONSHIP	PHONE NUMBER

PERSON RESPONSIBLE FOR ACCOUNT ☐ **same as above**

FIRST NAME MI LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
STREET ADDRESS	CITY, STATE, ZIP CODE	
HOME PHONE CELL PHONE	EMPLOYER	WORK PHONE EXT.

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE (Policyholder Information)

FIRST NAME MI LAST NAME	**DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**
STREET ADDRESS	**CITY, STATE, ZIP**	**PHONE NUMBER**
INSURANCE COMPANY NAME	**STREET ADDRESS**	**CITY, STATE, ZIP CODE**
EMPLOYER	**INSURANCE ID #**	**GROUP #**

SECONDARY DENTAL INSURANCE (Policyholder Information)

FIRST NAME MI LAST NAME	**DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**
STREET ADDRESS	**CITY, STATE, ZIP**	**PHONE NUMBER**
INSURANCE COMPANY NAME	**STREET ADDRESS**	**CITY, STATE, ZIP CODE**
EMPLOYER	**INSURANCE ID #**	**GROUP #**

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above. I will forward all insurance benefits, if any, to Dr. Farr, Dr. Brown, or Dr. Chahal that are made payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

_____ _____ _____

Responsible Party Signature **Relationship** **Date**

BILLING CHARGES: **1.5% Billing charge will be added to all accounts outstanding after 45 days. 1.5% Periodic rate, 18% Annual rate Any past due account referred to our collection service is subject to a 35% handling charge.**

PLEASE ANSWER IMPORTANT MEDICAL QUESTIONS ON BACK