PATIENT INFORMATION **Dr. David M. Boyd, DMD**

Today's Date:____/____/____ Birth Date:____/____/____ Age:________ Male_____ Female_____

First Name: ____________________________ Last Name: __________________________ M.I._____

Mailing Address:____________________________________City ___________________ Zip ______

Home Ph. (____) ____________________________ Cell. Ph. (____) ____________________________

Social Security Number __________________________Email Address: __________________________

Workplace ____________________________________ Work Ph (____) __________________________

Marital Status: (Circle 1) Married Single Divorced Widowed

Spouse's Name:_________________________________Ph.(____) ____________________________

Do You Have Dental Insurance? ________ Name of Insurance Company _________________________

Policy Holder Name:____________________D.O.B. ____/____/____S.S. # ____________________

Policy Holder Work Place ____

Emergency Contact Name:_________________________________ Ph. (____)____________________

Relationship:_________________________ Address: ______________________Zip________

Who Told You About Us? ____

If Patient Is Under Age 18, Please Complete This Section

Father:__________________________________ Mother ____________________________________

Person Responsible For Account:______________________________ Relationship_______________

S.S. # ____________________ D.O.B. ____/____/____ Home or Cell. Ph. (____) ______________

Billing Address (If Different):____Zip________

I Understand That Payment Is Due At The Time Of Service.

I Will Pay Today By: Cash ____ Check ____ Credit Card ____

I verify that the preceding information is true. I understand that I will be informed of all treatment plans and fees associated with my dental care. I agree to be responsible for all charges for dental services and materials not paid for by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent prohibited by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. I also acknowledge that I have been given or offered a copy of the office's Notice of Privacy Practices..

Signature Of Patient, Parent Or Guardian:__________________________________ Date:____________