

PLEASE COMPLETE THIS FORM AND
BRING IT TO YOUR APPOINTMENT.
ALSO, IF YOU HAVE INSURANCE
PLEASE BRING A COMPLETED
INSURANCE FORM. THANK YOU.

Dr. David D. Mentz

Welcome to Our Office
Patient Information

Orthodontist

Name _____	Nickname _____
Patient Address _____	City _____ State _____ Zip _____
Home Phone _____	Date of Birth _____ Age _____
Sex ___M___F School _____	Grade _____

Parent Information

Father's Name: _____
Address: _____
Phone:(work or cell if different than above) _____
Birthdate: _____ S.S.# _____
Employer: _____ Occupation: _____ Number of years employed: _____
Marital Status: _____ If divorced or separated, who has custody? _____
Mother's Name: _____
Address: _____
Phone:(work or cell if different than above) _____
Birthdate: _____ S.S.# _____
Employer: _____ Occupation: _____ Number of years employed: _____
Marital Status: _____ If divorced or separated, who has custody? _____

Please indicate who will be in charge of billing:

Dental Insurance Information

Insured's Name _____	Insured's I.D. # _____
Insurance Company _____	Group # _____ Phone # _____
Insurance Company Address _____	
Do you have dual coverage _____ Yes _____ No if yes:	
Insured's Name _____	Insured's I.D. # _____
Insurance Company _____	Group # _____ Phone # _____
Insurance Company Address _____	
Insured's Employer _____	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____