HollowBrook Dental

DR. L. LEE SMITH II, DDS
DR. ERIC ERLANDER, DDS
DR. THOMAS PERVOLARAKIS, DDS

PATIENT INFORMATION

_____ _____ _____
FIRST NAME MI LAST NAME

Please select: Minor Married Single Male Female

_____ /_____ /_____ _____ - _____ - _____
DATE OF BIRTH SOCIAL SECURITY NUMBER

_____
ADDRESS CITY / STATE / ZIP

_____ _____
HOME PHONE WORK PHONE

_____ _____
CELL PHONE EMAIL

MAY WE SEND YOU TEXT MESSAGES? YES NO

INSURANCE INFORMATION

_____ _____ _____
INSURANCE PROVIDER MEMBER ID GROUP NUMBER

_____ _____ _____
INSURANCE MEMBER NAME MEMBER SSN MEMBER DOB

_____
INSURED'S EMPLOYER

HollowBrook Dental

DR. L. LEE SMITH II, DDS
DR. ERIC ERLANDER, DDS
DR. THOMAS PERVOLARAKIS, DDS

EMERGENCY CONTACT

_____ _____ _____
NAME RELATIONSHIP PHONE

_____
ADDRESS CITY / STATE / ZIP

Has any member of your family ever been treated in our office? Yes No

Who can we thank for referring you to our office?_____

AUTHORIZATIONS

I hereby authorize payment directly to the Dental Office of the group insurance benefits, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. You are ultimately responsible for payment on your account. Returned checks are subject to a $26.00 service charge.

_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE