PATIENT INFORMATION

CAROLINA DENTAL CENTER
R. Jason Meares, DDS, PA

DATE _____

NAME _____
First Middle Last

Preferred name _____

Mailing Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Cell phone _____ Email _____

Social Security # _____ Date of Birth _____

Employer _____Business Address_____

Marital Status _____ Spouse's name _____

Spouse's Employer/Phone _____

Person responsible for account _____

Are you covered by dental insurance? ____ yes ____ no

Name of Insurance _____ Phone _____

Name of Insured _____ Date of Birth of Insured _____

SS# of Insured _____ Group # _____ Policy # _____

Referred by _____

CONSENT: I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicines, laboratory, x-ray, or other diagnostic studies that may be used by the dentist, his assistant, his hygienist or qualified designate.

INSURANCE: I authorize this office to furnish information to my carrier concerning the patient and or treatment. I assign to the dentist all payments for dental services rendered to me or my dependents. I understand that I am responsible for payment at the time services are rendered.

Signature _____ Date _____