



Neil G. Baird DDS

WE WOULD LIKE TO GET TO KNOW YOU BETTER

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_
Alternate Phone \_\_\_\_\_ Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_
Responsible Party \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Information:

Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_
Are you covered by another insurance plan?
Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_
Second Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Table with dental health questions and checkboxes. Columns include 'Yes or No' and 'Yes or No'. Questions cover tooth sensitivity, dental problems, and general health.

Payment Policy: Fees for all dental treatment are due and payable when completed unless prior arrangements have been made. A finance charge of 14% per annum will be charged on all balances 60 days and older.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_