Corinth Dental Care

Tricia Halford, D.D.S.

Last Name **First Name** **Middle** **Preferred Name**

Street Address **Apt. #** **City** **State** **Zip Code**

Social Security Number **Date of Birth** **Age** **Legal Sex:** **M / F**

Home Phone **Cell Phone** **Gender, if different from above:**

Employer **Spouse's Name** **Employed By**

Employer's Address **Employer's Address**

Occupation **Work Phone** **Occupation** **Work Phone**

How did you hear about our practice? **E-mail Address**

What is your preferred method of communication? Email_____ Text_____ Both_____

Nearest friend or relative not living with you? _____ Relationship to Patient _____Phone_____

POLICYHOLDER OR FINANCIALLY RESPONSIBLE PERSON

☐ **Check here if same as patient & disregard this section**

Last Name First Name Middle Relationship to Patient

Street Address Apt. # City State Zip

Date of Birth Social Security # Home Phone

Employer Business Phone

INSURANCE INFORMATION

☐ **Check here if you have brought your insurance id card and disregard this section.**

	Primary Insurance	**Secondary Insurance**
Ins. Co. Name		
Mailing Address		
City, State, Zip		
Area Code/Phone		

METHOD OF PAYMENT: Check ☐ Cash ☐ Credit Card ☐

Our office policy is PAYMENT AT THE TIME OF SERVICE. However, we will be glad to assist you in the filing of your insurance. We will hold your insurance claim for 60 days after which it becomes your responsibility. Finance charges of 33.33%-45% may be added to overdue accounts. There will be a $20.00 charge for all returned checks. Should attorney's fees be incurred in collecting your account, you will be required to pay those fees. I hereby authorize the release of any medical information necessary to process this claim and also authorize payment of medical benefits to Dr. Halford for services rendered. A copy of this authorization and assignment shall be considered as valid as the original.

SIGNATURE _____ DATE_____