Anthony B. Rainwater, D.D.S., MS

PATIENT INFORMATION

Patient Name _____ SS# _____
Address _____ Home Phone _____
City _____State _____Zip_____Work Phone _____
Date of Birth _____Emergency Contact Number _____
Employer _____
Employer Address _____
General Dentist _____Referred by _____

FINANCIALLY RESPONSIBLE PERSON

Responsible Person _____Relationship _____
Address _____ Home Phone _____
City_____State_____Zip_____ Work Phone _____
Date of Birth _____ SS# _____
Employer _____
Employer Address _____

DENTAL INSURANCE INFORMATION

Insurance Company _____
Address _____
Policy # _____ ID# or SS#_____
Secondary Insurance _____ID# or SS#_____
Address _____

Method of Payment (Circle One)
Cash Check MasterCard Visa Care Credit

I understand that my insurance will be filed as a courtesy to me and all fees not covered by insurance are due at the time services are rendered. No balance shall be carried by Dr. Rainwater's office for more than thirty (30) days after insurance has been filed.

I authorize the release of any information including the diagnosis and the records of any examination and/or treatments rendered, to any other health care providers, such as my dentist or physician, who may be involved in my care.

Patient/Guardian _____Date_____