WELCOME TO OUR OFFICE

YOUNG DENTISTRY, PC

674 Rogers Street - Lowell, MA 01852

978-459-0594 TODAY'S DATE:

Thank you for choosing our office.

In order to serve you properly we will need the following information. All information will be strictly confidential.

PATIENT'S NAME: BIRTHDATE:

HOME ADDRESS: CITY: STATE: ZIP: HOME TELE PHONE:

NAME OF EMPLOYER: CITY: BUS. TELEPHONE:

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: RELATIONSHIP TO PATIENT:

SOCIAL SECURITY # OF PATIENT: SOCIAL SECURITY OF RESPONSIBLE PERSON:

NAME OF DENTAL INSURANCE CO: ADDRESS:

SUBSCRIBER NAME: DATE OF BIRTH: G ROUP NUMBER:

EMPLOYER FOR ABOVE SUBSCRIBER: ADDRESS:

SECONDARY INSURANCE: ADDRESS:

SUBSCRIBER NAME: DATE OF BIRTH: SOCIAL SECURITY #

WHOM MAY WE THANK FOR REFERRING YOU?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature_____Date_____