BETHESDA WALK DENTAL CARE
Dr. Billy S. Pealock, D.M.D.

PATIENT INFORMATION

Name: ____Date: _______________________________

Address: ____

City: ____ State: ______________________Zip: ___________________

Home Phone #: (________) ________-________________ Cell Phone#: (________) _________-______________

E-mail Address: ____

Birthdate: __________________________________ Social Security #: ____

Marital Status: ________________________________ Drivers License #: _____________________________________

If College Student-Name of School: ____

Emergency Contact Name: _________________________________Phone #: (________) __________-___________

Whom May We Thank for Referring You? ____

DENTAL INSURANCE INFORMATION

Name of Insured: _______________________________________Relationship to PT: __________________________

Birthdate of Insured: _____________________________ SS# of Insured: __________________________________

Employer Name of Insured: ____

Insurance Company: ____ Phone: _____________________________

Insurance Co. Address: ____

Policy ID #: _____________________________________ Group #: ____

As a courtesy, we will file your primary insurance claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due at the time of my visit. Any portion of treatment that the insurance company does not cover is the patient's responsibility. I grant the right of Dr. Billy Pealock to release health information about me and information about my dental treatment to third party payors and/or other health practitioners. I consent to treatment for myself/family under 18 years old. There will be a charge for broken or cancelled appointments without 24 hours advance notice.

Signature: ____ Date: ____________________

Print name: ____ Patient #: _______________