Mobile Dentistry & Hygiene
PO Box 22145
Milwaukie, OR 97269
Phone: 503-632-4914
Jeanett@PrimeMobileDental.com

Patient Name: ____
Date of Birth: ____

Patient Place of Residence
Name (if applicable): ____
Address: ____
City, State, Zipcode: ____
Phone number: ____
Best contact person (if known): ___________________________________

Responsible Party (used for billing):
Name: ____
Relationship to Patient: ____
Check the ones that apply:

___ Power of Attorney – Financial
___ Power of Attorney – Health Care
___ Guardian / Conservator

Address: ____
City, State, Zipcode: ____
Phone Number: ____
Email: ____

Do you have dental insurance to bill? Yes or No
Insurance company: ____
Please provide a copy of the front & back of the insurance card.
We will gladly submit an insurance claim on your behalf but we are not an in-network dentist; you will be responsible for balance remaining.

I agree that the above information is current and accurate.

___________________________	________________________	_________________
Authorizing Signature	Relationship to Patient	Date