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. 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. **Note: If your balance is not paid and you are sent to collections, you will owe the balance plus a 35% collection fee.**

Signature: _____ Date: _____

Print name: _____ Patient #: _____