LORIE R. MARSH, DMD, P.C
FAMILY DENTISTRY

Section 1:Patient Information

Name:_____ Name I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (____)_____ Work Phone (_____) _____ Cell Phone (____)_____

Date of Birth:_____/_____/_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Parent's Name: _____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Email Address_____Would you like to receive text confirmations? ☐ Yes ☐ No

Section 2: Insurance Information

Name of Policy Holder_____ DOB____/____/____ Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Insurance Company_____ Grp #_____ ID#_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Policy Holder_____ DOB____/___/_____ Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Insurance Company_____ Grp #_____ ID#_____

I Certify that I and/or my dependent(s) have insurance coverage with _____and assign directly to Dr. Lorie Marsh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr Marsh and staff may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature X_____ Date _____

Section 3: Responsibility and Consent Statement

I give my consent to any advisable and necessary dental procedure, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or my dependent(s), regardless of insurance coverage

I understand that 24 hours notice is required when cancelling an appointment. Failure to cancel in time could result in a $50 fee.

Signature of Patient, Parent, or Guardian **X**_____

Section 4: Medical and Dental History

Name and Address of Physician _____

Last Complete Physical?_____

Have you ever had a serious illness or operation? YES _____ NO _____ If Yes, Please Describe _____

Have you ever had an artificial joint replacement? YES_____ NO _____ If Yes, When? _____

Do you take, or have you ever taken IV or Oral Bisphosphonates such as Fosomax, Boniva, Actonel, Reclast, Aredia? YES __ NO ___