W A Scholtz (Drew) Scholtz DDS PLC
231-744-4784

Patient Information

Patient Name_____Date_____
Last First MI
Social Security #_____ Gender_____ Birth Date_____

Address_____Email_____
Street City State Zip Code
Home Phone_____ Work _____Ext_____ Cell phone_____
Please circle number you want to be used as your primary contact number.

Employer_____position_____shift_____

Emergency Contact Person_____Phone Number_____

If you are a new patient, how did you hear about us: website____person_____other_____

Spouse or Responsible Party Information

Name_____ Relationship to patient_____

Address_____

Phone (home)_____ (work)_____Ext_____ (cell)_____

Dental Insurance Information

Primary
Name of Insured_____Insured's Birth Date_____
Last First MI
Contract # _____Social Security #_____ Group #_____

Insured's address_____
Street City State Zip Code
Insured's Place of Employment _____Relationship to patient?_____

Insurance Company Name_____ Phone #_____

Secondary Insurance
Name of Insured_____Insured's Birth Date_____
Last First MI
Contract # _____Social Security #_____ Group #_____

Insured's address_____
Street City State Zip Code
Insured's Place of Employment _____Relationship to patient_____

Insurance Company Name_____ Phone #_____

Consent for Services

- All services performed must be paid for at the time the service was rendered.
- We will legally look to the guardian bringing the dependant to the office requesting care for payment of fees. We are not responsible for enforcing divorce decrees or separation agreements.
- Patients who carry dental insurance understand that all services furnished are charged directly to the patient and he or she is personally responsible for payment of all services. This office as a courtesy, will prepare insurance claims and assist in making collections from insurance companies. We will credit any payments to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.
- I have read the above conditions of treatment and payment and agree to their content.
- This signature on file is my authorization for release of information necessary to process my claims and my dependents. I hereby authorize payment directly to W A (Drew) Scholtz DDS PLC, otherwise payable directly to me.

_____ Date_____
Signature of responsible party