DENTAL ASSOCIATES OF WALPOLE

1428 Main Street, Suite 1
Walpole, MA 02081
Tel: 508.668.8008
Fax: 508.668.8808

Family Account Information

Patient's Names: **Date of Birth:** **Gender:**

_____☐M___☐F_____
_____☐M___☐F_____
_____☐M___☐F_____
_____☐M___☐F_____
_____☐M___☐F_____

Date: _____

Name of Financially Responsible Person: _____
Last First MI

Social Security Number (Required): _____

Date of Birth: _____

Gender: ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Divorced ☐ Other

Address: _____
Street City State Zip Code

Phone Numbers

May we leave messages regarding treatment, appointments or billing at these numbers?

Home:	☐Yes ☐No
Cell:	☐Yes ☐No Text? ☐Yes ☐No
Work: ext:	☐Yes ☐No

I understand that I am responsible for the cost of all dental treatment. I also understand that I am responsible for paying any copayments or deductibles that the insurance does not cover. I understand that I will be responsible for any fees if 3rd party collection efforts are required to collect a balance and for any returned check fees. I also understand that there will be a charge for any missed appointments or appointments cancelled with less than 24 hours notice to Dental Associates of Walpole.

Signature of Person Financially Responsible:

_____**Date:** _____

Dental Insurance:

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Subscriber ID #: _____ **Group #:** _____
(Required)

Employer: _____

Name and State of Insurance Company: _____

I hereby authorize release of any information including diagnosis and records of treatment or examination to my insurance company.

Signature: _____ **Date:** _____

Medical Insurance:

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Subscriber ID #: _____ **Group #:** _____
(Required)

Employer: _____

Name and State of Insurance Company: _____

I hereby authorize release of any information including diagnosis and records of treatment or examination to my insurance company.

Signature: _____ **Date:** _____