Patient Information
Name
_____Date_____
Address
_____
_____
Email _____
Phone Number
cell:_____home:_____
May we text you appointment reminders? YES___NO___
Social Security # _____
DOB _____
How did you hear about our office?_____

Responsible Party Information (if not patient)
Name
_____Relation_____
Social Security #
_____DOB_____
Address
_____
Phone Number _____

Insurance
Name of Primary Insured _____
Employer_____DOB _____
Social Security#_____
Address
_____
Please provide a copy of insurance card and valid driver license.

I authorize payment of dental benefits to David A. Herald, DDS for professional services rendered and the release of any dental information necessary to process claims.

Signature Date