G. Mitchell Turk, D.D.S., M.A.G.D.

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CONFIDENTIAL PATIENT INFORMATION

Please print or write legibly

PERSONAL INFORMATION   Referred By:

Name: ______________________________ M.I. __________ SS# ________________

Address: ________________________ City: ____________State: ________ Zip: _______

Phone: ________________ Bus. Phone: ________________ Cell Phone: ________________

Birthdate: __________ Sex: ____ Marital Status: _________ Spouse Name: __________________

Occupation: ____________________________ E-Mail Address: ______________________

Person to contact in emergency Name: ________________Relationship:_____ Home Phone:______

Address: ______________________________Cell Phone: _______Bus. Phone: _________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____

D.O.B.: ______________ Driver's Lic: ____________________Phone: ________________

Address: ________________________ City: ____________ State: ________ Zip: ______

Phone: ______________ Bus. Phone: ___________________ Cell Phone: ______________

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: ____

Address: ______________________ City: _____________State: ________ Zip ______

Employee: _____________ Relationship: ________ SS# ___________ D.O.B.__________

Employer: _____________________________ Policy Number: _____________________

Secondary Insurance Co.: ____

Address: ______________________ City: _____________ State: _______ Zip: ______

Employee: ______________ Relationship: ______ SS#: _____________ D.O.B. _________

Employer: _____________________________ Policy Number: _____________________

Employer phone no.: ____

Please advise two business days notice prior to appointment change and to avoid cancellation charge.
I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: ________________________________	Date: ____________________