feather touch dental care

Welcome to Feathertouch!

About You…

Date_____ File #_____

Patient Name _____ Name you prefer to be called _____

Last First MI

Birthdate_____ age_____ ❒ Male ❒ Female SS# _____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____Work_____ Cell_____

Email_____

How did you hear about our office? _____

Employer_____ Occupation_____

Employer's Address_____

City_____ State_____ Zip_____

❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Partner Spouse's Name _____

Do you have children? ❒ Yes ❒ No How Many_____

Account Information…

Person Responsible for Account

Name_____Relationship_____

Billing Address_____

City_____State_____Zip_____SS#_____Driver's License #_____

Work Phone _____ Payment Method ▫ Cash ▫ Check ▫ Card Credit Card #_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company(if offered at this office).

Initial_____