Patient Information

Name_____

Address_____

_____

Phone # – Home_____ **E-mail** _____

Work_____

Cell_____

SS#_____

Place of Employment_____

Date of Birth_____

Spouse's Name_____

Spouse's Place of Employment_____

Spouse's Date of Birth_____

Spouse's SS#_____

Dental Insurance Information – Carrier_____

Group #_____ **Subscriber #**_____

Financial Agreement

I understand that I am responsible for the full payment of services rendered. I understand that if I have insurance, the office of Stanley P. Young, D.D.S. files my insurance as a courtesy, and I am still responsible for the full payment of services rendered.

Signature_____