



Jacqueline Bennett D.D.S

Art Of Dentistry

Welcome Information

*In order to serve you properly, we will need the following
All information will be kept confidential*

PERSONAL

Name _____

Last

First

MI

(Preferred)

Birthdate _____ SS# _____ Gender: M ___ F ___ Married: Y ___ N ___

How did you hear about us? _____

(If someone referred you here, please write down their name so we can thank them.)

CONTACT INFORMATION

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Email _____ Preferred Contact Method _____

Emergency Contact _____ Contact Phone # _____

INSURANCE POLICY 1

Relationship to Subscriber: Self ___ Spouse ___ Child ___

Subscribers: Name _____ ID # _____ DOB: ____/____/____

Insurance Company _____ Phone # _____

Employer Name _____ Group # _____

INSURANCE POLICY 2

Relationship to Subscriber: Self ___ Spouse ___ Child ___

Subscribers: Name _____ ID # _____ DOB: ____/____/____

Insurance Company _____ Phone # _____

Employer Name _____ Group # _____

PAYMENT

Payment or verification of insurance coverage is required at time of treatment. For payment of fees for paying your portion of fees not covered by insurance, we accept the following payment options:

Cash ___ Check ___ MasterCard ___ Visa ___ American Express ___ Discover ___ Care Credit ___

I hereby authorize my insurance benefits to be paid directly to Jacqueline Bennett DDS, PLC and I authorize the doctor to release any information to process insurance claims.

Date _____ Signature _____