MICHAEL S. PUGH, D.M.D., P.C.
Dentistry

*Welcome to our practice!* Date: _____

## PATIENT INFORMATION

Name: _____ Birthdate: _____ ❑ F Sex ❑ M
Last First Middle Mo Day Year

Address _____
Street Apt# City State Zip

Soc Sec # _____ Married ❑ Single ❑ Minor ❑ Employer (or School) _____

Phone #'s _____
Home Work Cell

Email: _____

Whom may we thank for referring you to our office? _____
Has any member of your family ever been treated in our office? _____
What name do you prefer to be called? _____ Name of Spouse? _____

## ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Birthdate: _____ Relationship: _____
Last First M Mo Day Year

Address: _____
Street Apt# City State Zip

Soc Sec # _____ Driver's License # _____

Phones: _____
Home Work Cell

Occupation: _____ Employer: _____

## DENTAL INSURANCE INFORMATION

Insured's Date of Birth _____

Insurance Company: _____ Group No. _____

Policy Holder: _____ Employer: _____

ID or Policy #: _____ Insured's SS#: _____

Phones: _____
Home Work Cell

Are you covered under more than one dental plan? ❑ YES ❑ NO
If yes, please fill out next section. Insured's Date of Birth _____

Insurance Company: _____ Group No. _____

Policy Holder: _____ Employer: _____

ID or Policy #: _____ Insured's SS#: _____

Phones: _____
Home Work Cell

**About Your Account...**
We will make every effort to make your dental needs financially comfortable for you. In general, payment is required at the time of the service unless other arrangements are made in advance. A re-billing fee of 1 - 1 ½% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding sixty (60) days unless previous written financial arrangements are satisfied. All collection charges and reasonable attorney's fees incurred to effect collection on this account shall be paid by the patient.

I have received a copy of this office's Notice of Privacy Practices.

**Signature:** _____ **Date:** _____