Southwest Dental Associates

Helen H. Harless, D.D.S., F.A.G.D.

Patient Information

Name _____ Birth Date ____/____/____

Phone _____ Email _____

Address _____ City _____ State _____ ZIP _____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Marital Status: Minor ☐ Single ☐ Married ☐ Widowed ☐

Patient's/Parent's Employer _____ Position _____

Work Address _____ City _____ State _____ ZIP _____

Emergency Contact _____ Relationship _____ Phone _____

Guardian *(if Patient is a Minor)*

Guardian Name _____ Birth Date ____/____/____

Phone _____ Employer Phone _____

Address _____ City _____ State _____ ZIP _____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Relationship to Patient _____

Dental Insurance

Name of Insured _____ Birth Date ____/____/____

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date Effective _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ City _____ State _____ ZIP _____

Signature

I understand the responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1½% finance charge per month (18% annually) will be added to any balance over 60 days. In the event of default, I/we promise to pay legal interest on the indebtedness, together with collection costs and attorney fees as may be required to effect collection on this note. I cetify that the above information is true and correct and consent to a credit check based on that information. I agree to be, and hereby am, fully responsible for the total payment of the charges for procedures performed in this office, including any amounts not covered by any dental insurance or prepayment plan that I/my spouse may have.

Signed _____ Date _____

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