JAMES C. WEST, D.D.S., M.S.

Pediatric/Adolescent Dentist and Orthodontist

PATIENT INFORMATION

Date: _____ ☐ Female ☐ Male

Patients Name: _____
Last First Middle

Address: _____
Number & Street Address City State Zip

Home Phone: _____ Birth Date: _____ Age: ____ Soc Sec #: _____

If patient is a minor, name of legal guardian: _____

Whom may we thank for referring you to our office: _____

Name of your Pediatrician/Physician: _____ Phone: _____

Name of your Dentist: _____ Phone: _____

RESPONSIBLE PARTY

Name: _____ _____
Last First Middle Martial Status

Residence: _____
Street Address City State Zip

How long at this residence: _____ Home Phone: _____

Previous Residence (if less than 3 years):_____
Street Address City State Zip

Insured Soc. Sec. # _____ Insured Date of Birth _____

Employer: _____ No. Years Employed Here: _____

Occupation: _____ Work Phone:_____

Cell Phone: _____ E-Mail: _____

Spouse's Name: _____
Last First Middle

Residence: _____
Street Address City State Zip

Soc. Sec. # _____ Date of Birth _____

Employer: _____ No. Years Employed Here: _____

Occupation: _____ Work Phone:_____

Cell Phone: _____ E-Mail: _____

EMERGENCY INFORMATION

Name of Nearest relative not living with you: _____

Complete Address: _____

Home Phone: _____ Cell Phone: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature:_____ Date: _____

JAMES C. WEST, D.D.S., M.S.

Pediatric/Adolescent Dentist and Orthodontist

I understand that I am fully responsible for any and all fees associated with the dental treatment provide to me or my children by James C. West, D.D.S., M.S.

Upon default, I or we jointly or severally agree to pay all costs of collection, including reasonable attorney's fees and court cost. I also understand that I will be charged a $10.00 billing fee for additional monthly statements if I fail to pay after receipt of the first statement.

Name: _____ Date: _____
Last First Middle

Address: _____
Number & Street Address City State Zip

Signature: _____

INSURANCE INFORMATION

Name of Insured: _____ _____
Last First Middle Martial Status

Insured Soc. Sec. #: _____ Insured Date of Birth: _____

Employer: _____ Occupation: _____

Employer Address: _____
Number & Street Address Suite # City State Zip

Insurance Company: _____ Group #: _____

Insurance Company Address: _____
Number & Street Address City State Zip

Insurance Phone#: _____ E-Mail: _____

I am providing this insurance information so that a claim for re-imbursement may be submitted on my behalf. I further understand that the submission of an insurance claim for dental services performed does not guarantee payment by the insurance company listed above.

I also understand that I must provide the office of James C. West, D.D.S., M.S. accurate and current insurance information at all times in order to facilitate proper filing of claims

If benefits have been assigned to James C. West, D.D.S., M.S. and a payment has NOT been received within sixty (60) days following submission of an insurance claim I agree to promptly pay any and all outstanding fees which have not been paid.

Name as it appears on the card: _____

Card Type: _____ Credit Card Number: _____

Expiration: _____ Security Code: _____

Signature: _____ Date: _____