Lawson Evans, DDS

1805 Novato Blvd., Ste. 4, Novato, CA 94947 (415) 898-0696

Date _____

ACCOUNT INFORMATION

Mr./Mrs./Miss/Ms._____ Occupation _____
Last Name First Name

Mailing Address _____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Birthdate_____ Social Security Number_____-_____-_____

Employer _____
Company Street City State Zip

Who referred you to our office? _____

Previous Dentist _____ Date Last Seen _____

SPOUSE INFORMATION

Spouse's Name_____ Occupation _____

Birthdate_____ Social Security Number_____-_____-_____

Employer _____ Work Phone (_____) _____
Company Address

INSURANCE INFORMATION

AS A COURTESY, WE WILL PROVIDE YOUR INSURANCE FORM AND AUTOMATICALLY PROCESS IT FOR YOU.

Insurance Co. #1 _____ Group # _____

Insurance Co. Address _____ Untion Local # _____

Insurance Co. Phone (____) _____ Policyholder Name _____ Member ID# _____

Insurance Co. #2 _____ Group # _____

Insurance Co. Address _____ Union Local # _____

Insurance Co. Phone (____) _____ Policyholder Name _____ Member ID# _____

I hereby authorize the release of any information, including the diagnoses and the records of any treatments or examinations rendered, to my insurance company or companies, other practices or specialists.

I further agree to the use of my signature on file here to authorize payment directly to this dental office of the group insurance benefits otherwise payable to me.

I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance.

Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

There will be a late cancellation fee charged for appointments that are cancelled within 24 hours.

_____ _____ **OR** _____ _____

Signature of Patient Date *Signature of Responsible Party* Date