SOUNDVIEW
Family Dental
Eric D. Kitts, DDS

PATIENT INFORMATION

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Today's Date: _____

Patient's Name: _____ MI: _____ Preferred Name: _____

Birth Date: _____ Patient's Social Security #: _____

Please circle: Title: Mr. / Mrs. / Ms.

Family Status: Married / Single / Divorced / Widowed / Child / Other

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile Phone # : _____

Email Address: _____

Employer: _____ Title: _____

Work Phone #: _____

Name of Previous DDS: _____ Date of last visit: _____

If minor:

Father: _____ Work #: _____ Mobile #: _____

Mother: _____ Work #: _____ Mobile #: _____

Spouse Name: _____

Spouse Birth date: _____ Spouse Social Security #: _____

Spouse's Employer: _____ Work # : _____

Mobile #: _____

Person Responsible for Account: _____ Birth date: _____

Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PERSON TO CONTACT IN EMERGENCY: _____

PHONE #: _____

Referred To Our Office By: _____

PLEASE CONTINUE TO THE OTHER SIDE →

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INSURANCE INFORMATION

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PRIMARY

Subscriber:_____ Birth Date:_____

Employer:_____

Insurance Company:_____

Insurance Co. Phone #: _____

Group #: _____ Insurance ID or SS#: _____

SECONDARY

Subscriber:_____ Birth Date:_____

Employer:_____

Insurance Company:_____

Insurance Co. Phone #: _____

Group #: _____ Insurance ID or SS#: _____

We will bill your dental Insurance for you, however you are personally responsible to Dr Kitts for your bill and any portion the insurance does not cover. Please note that some services may not be covered and most services are rarely covered in full. We do have a 1% per month finance charge on all balances over 90 days. Please note that in order to avoid a fee, we require a 48 hour notice for cancellations and more notice is greatly appreciated. When you make an appointment, we reserve that time just for you.

By signing this form, I consent to Dr Kitts and his staff using my protected health information to carry out treatment, bill insurance, collect payment, send records and x-rays to a referral doctor, and all other usual and customary health care operations. I authorize Dr Kitts to collect payment directly from my insurance company and I agree to pay the balance outstanding. I also authorize Dr Kitts office to mail postcard appointment reminders to my house and leave recorded appointment reminders on my phone recorder.
I have read and understand the insurance and financial policies:

Signature_____ **Date**_____