William S. Wooten, DDS, PA

Welcome to Our Practice!

Patient Information

Name _____ **Birth Date** _____
Address_____
City _____ **State** _____ **Zip**_____
Sex: M F Age _____ **Marital Status: S M D W**
Home Phone _____ **Work Phone** _____
Cell Phone _____ **E-mail address**_____
SSN _____ **DL**_____
Notify in Case of Emergency_____
Phone Number for Emergency Contact_____
Employer:_____
Employer Address:_____
Employer Telephone #:_____

Whom May We Thank For Referring You? _____

Insurance Information

Policy Holder_____
Relation to Patient_____
D.O.B. _____ **SSN** _____
Address (if different than Patient) _____
City _____ **State** _____ **Zip**_____
Home Phone _____ **Work Phone**_____
Employer _____
Insurance Co._____
Employer Address:_____
Employer Telephone #:_____

I authorize my dentist to release necessary information to secure payment of benefits. I understand after 30 days, I am financially responsible for all charges whether or not paid by insurance.

I verify all information given is correct.

Signature
_____**Date**_____
(Patient/Parent/Guardian)

Payment is normally expected at the time of service. However, on occasion, our patients request a payment plan for their treatment. If you feel at some point you would like to arrange monthly payments for future treatment, please indicate below.

I, _____ **authorize Dr. Wooten to obtain my credit report in the event that I request a payment plan for my treatment.**

Signature _____ **Date**_____