

William L. DeWitt D.D.S., PLC
Family Dentistry

We welcome you as a patient!
PLEASE PRINT

326 North Ferry, Suite B
Grand Haven, MI 49417-1462
Phone: 616-842-3480
Fax: 616-842-9997

NAME Last _____ First _____ MI _____

ADDRESS Street _____ City _____ State _____ Zip _____

PHONE Home _____ Work _____ SS# _____

BIRTHDATE _____ Spouse's Name _____

EMPLOYER OF PATIENT _____

PERSON RESPONSIBLE FOR PAYMENT _____

Do You Have Dental Insurance? Yes No What kind? _____

Any dental complaints? _____

Do you smoke? Yes No Chew tobacco? Yes No
Would you like whiter teeth? Yes No Are you concerned about your breath? Yes No
Would you like fresher breath? Yes No
When I hear about U of M I think about the University of Minnesota. Yes No

Who may we thank for referring you? _____

Why did you leave your last dental office? _____

Please give the name and phone number of the closest relative not living with you in case of emergency

Physician's name _____ Date of last exam _____

Have you been hospitalized within the last five years? Yes No
If yes, for what? _____

Have you ever responded unfavorably to dental or medical care? Yes No

What medications are you now taking? _____

Have you ever been told to take antibiotics BEFORE dental treatment? Yes No
If so, what? _____

What are you allergic to? No known allergies Aspirin Codeine Penicillin
 Latex Local Anesthetic Metals Jewelry Dentists
 Other _____

I have had—or—I am now being treated for the following medical conditions:
 Asthma/Bronchitis Diabetes Hepatitis Nervousness
 AIDS Fainting Spells High Blood Pressure Now Pregnant
 Bleeding Tendency Heart Problems: HIV Recent Stress
 Cancer (Damaged Heart Valve, Joint Replacement Rheumatic Fever
 Convulsions/Epilepsy Heart Murmur, Pace-Maker) (Hip, Knee, etc.) Other: _____

Signature _____ Date _____

PATIENT FINANCIAL INFORMATION

A. Patients With No Dental Insurance Coverage

Payment for treatment is expected at the time of service unless payment arrangements have been made. We accept cash, checks, MasterCard, Visa, and Discover.

B. Patients With Dental Insurance Coverage

We accept dental insurance but may not participate in your plan. PLEASE ASK US!

We will be happy to help you process your insurance claim. The filing of insurance claims is a courtesy that we extend to our patients, as this can be rather confusing to you. Please bring your insurance benefit booklet and insurance card with you as this will help us to compute your portion of the fees. Insurance forms will be filed at the time of service. If we have difficulty we will ask you to contact your insurance company. A phone call from you carries much more importance than one from our office.

Who will be responsible for your account?

Name _____ Employer _____

Home address _____

Home phone _____ Business phone _____

If you have insurance, fill out the following information.

Primary Insurance Carrier

If you have double insurance coverage

Insured's Name _____

Insured's Name _____

Insured's Birthdate _____

Insured's Birthdate _____

Insured's Employer _____

Insured's Employer _____

Insurance Company _____

Insurance Company _____

Insured's S.S. # _____

Insured's S.S.# _____

Group # _____

Group # _____

PLEASE GIVE RECEPTIONIST INSURANCE CARD FOR COPYING!

The payment of all bills is your responsibility. Accounts more than 60 days from the treatment date will be referred to Transworld Systems, a pre-collection agency. Major treatment or treatment involving a laboratory procedure will require an appropriate down payment. If temporary financial problems arise that will affect your timely payment of your account please contact us immediately.

I have read the above information and agree to comply with the financial policy of William L. DeWitt D.D.S.

Signature of Patient, or Parent if patient is a minor

Date