Beyond Dental, P.C.

Carmen Moss, D.M.D.

Name:_____ Birthdate:____/____/_____

Address:_____

Sex (Circle One): M / F Soc Sec #:_____ Circle One: Married / Single / Minor

Preferred Name:_____ Name of Spouse:_____

Primary Phone: _____ Secondary Phone: _____

Occupation: _____ Employer (or School) :_____

Business Address: _____

Email Address: _____ Drivers License #: _____

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

List all members of your family that has been treated in our office: _____

Emergency Contact Name:_____ Phone #: _____

Person Responsible for Account (if different from above):

Name: _____ Birthdate: ____/____/_____ Relationship: _____

Address: _____

Soc Sec #: _____ Drivers License #: _____

Primary Phone: _____ Secondary Phone: _____

Occupation: _____ Employer: _____

Business Address: _____

Dental Insurance Information Insured's DOB:_____

Insurance Company: _____ Group #:_____ Insured's SS#: _____

Policy Holder: _____ Employer: _____ Phone: _____

Employer's Address: _____

Are you covered by more than one dental plan? Yes / No If so, fill out this section:

Insurance Company: _____ Group #:_____ Insured's SS#: _____

Policy Holder: _____ Employer: _____ Phone: _____

Employer's Address: _____

Are you satisfied with your smile? Yes / No
Payment will be collected at the time of service or before if reserving long appointments.
Do you prefer to pay: Cash / Check / Credit Card / Debit Card
Are you interested in our **In-Office Savings Plan**? Y / N Or **Care Credit**? Y / N

Signature: _____