Dentistry by Design MWC
dentistrybydesign@coxinet.net
7215 E. Reno
Midwest City, Oklahoma 73110

Patient Information

Last Name: _____ First Name: _____ M.I: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Birth Date: ___/___/_____ Sex: _____ Marital Status: _____ SSN: _____-_____-_____

Employer: _____ Occupation: _____

Emergency Contact (Not in your household): _____ Phone Number: (____) _____-_____

Email: _____

Responsible for Payment

☐ Check box if information is the same as above

Last Name: _____ First Name: _____ M.I: _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) ____-____ Work Phone: (____) _____ _____

Birth Date: ___/___/_____ Sex: _____ Marital Status: _____ SSN: _____-_____-_____

Employer: _____ Occupation: _____

Insurance

Insurance Company and Address: _____

ID: _____ Group Number: _____

Policy Holder: _____ Birth Date: ___/___/_____ SSN: _____-_____-_____

Secondary Insurance Company and Address: _____

ID: _____ Group Number: _____

Policy Holder: _____ Birth Date: ___/___/_____ SSN: _____-_____-_____

Authorization:

I authorize payment directly to Dentistry By Design for dental benefits when necessary. I also understand I am responsible for office charges at the time they are incurred unless I am covered by an insurance company in which the dentist participates. I am responsible for any portion of my bill not covered by my insurance company.

Signature (Parent/Guardian): _____ Date: ___/___/_____

Referred By: _____

Print completed form and bring to office with you or Save completed form and email to dentistrybydesign@coxinet.net