

WELCOME TO THE OFFICE OF DR. JACK B. SHARE

Thank you for selecting our dental health care team. We will strive to provide you with the best possible care. Please help us meet your dental needs by completely filling out this form. If you need assistance, we will be happy to help.

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Home Address _____ City _____ State _____ ZIP _____
Home Phone () _____ Work Phone () _____ Cell Phone () _____
Date of Birth / / Social Security Number - - Dental Insurance: Y N
Please Circle: MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

DENTAL INSURANCE INFORMATION

Relationship of patient to insured: SELF SPOUSE MINOR OTHER
Insured's Group Number _____ Insured's Name _____
Insured's ID Number _____ Insured's Date of Birth / /
Insured's Employer's Name _____
Insured's Employer's Address _____
City _____ State _____ ZIP _____
Insurance Company _____
Insurance Company's Address _____
City _____ State _____ ZIP _____
Phone () _____

GETTING TO KNOW YOU

Are there any family members that are also patients? _____
Who referred you to our office? _____
What is your occupation? _____
What is your spouse's occupation? _____
Who is the person to contact in the event of an emergency? _____ Phone () _____

YOUR FINANCIAL RESPONSIBILITY

- For patients with dental insurance, we will submit your insurance claims for processing as a courtesy. We can make no guarantee of coverage, but will do our best to see that you receive your maximum benefits. Should your benefits result in less coverage than anticipated or if you exceed your maximum benefit amount, you will be responsible for your total obligation. It is also your responsibility to pay at the time of service any deductible amount, co-payment or any other balance not paid or covered by your insurance.
- For patients without dental insurance, you are requested to pay in full at the time of service.
- If payment in full can not be made at the time of service, payment arrangements must be made with the receptionist.
- Please request a personal copy of Our Financial Policy at the front desk, also available at ShareThatSmile.com.
- We reserve the right to charge your account, if we are not notified of an appointment change within 24 hours.

I have read, thoroughly understand and agree to my financial responsibility.

SIGNATURE _____ DATE _____