J. Eric Hibbs, DDS, FAGD

www.ParkCitiesDental.com

5600 W. Lovers Lane @ Tollway #216 Dallas, TX 75209-4318 **214.351.2311**

		Patie	ent Information				
Patient Na	ame:						
☐ Male	Last e 🛭 Female	First	☐ Married ☐ Single	Prefer			
Social Sec	curity #:	Driver Lice	ense #:	(State)	Birth Date:		
Phone (Ho	ome):	(Work):	Ext: Cell:	Pager	:		
Address:							
	Street		Apartment #		l Address		
		State Zip Code Occupation:					
Address:	Street	Suite#	City	State	Zip Code		
How will	vou secure vour	account? Credit Card	d: #:	State	Expires:		
• Reason	for this visit:	□ I will pay fo	or treatment at time of particular of the control o	service during ead Last Dental Visit:	ch visit.		
• Are you	interested in. \Box	Fresher Breath Whi	iter reeth 🗖 Changing	g Appearance or	rour Smile		
□ AIDS □ Allergie □ Codein □ Penicill □ Sulfa A □ Anemia □ Arthritis □ Artificia □ Asthma □ Blood □ □ Cancer □ Diabete	ese Allergy in Allergy illergy as al Joints a Disease	f the following? Pleas Dizziness Epilepsy Excessive Bleeding Fainting Glaucoma Growths Hay Fever Head Injuries Heart Disease Heart Murmur Hepatitis High Blood Pressurutaking?	☐ Jaundice ☐ Kidney Disease ☐ Liver Disease ☐ Mental Disore ☐ Nervous Discente ☐ Pacemaker ☐ Pregnancy ☐ Due date: ☐ Radiation Tre ☐ Respiratory Formula Respiratory	ase See See See See See See See See See S	inus Problems tomach Problems troke uberculosis umors lcers enereal Disease THER:		
Have vo	ou ever had anv o	complications during or f	following dental treatme	ent? □No□Y	es:		
•	_	are of a physician?	-				
• Do you h	have any health	problems that need furth	ner clarification? DN	o 🛮 Yes:			
• Emerger Complete	ncy Contact: Nar te address:	ne of nearest relative no	ot living with you?	Phone	:		
	•	ge, all of the preceding any health, I will inform th		•			
Signature of	of patient, parent or gu	ardian		Date:			
		Refer	rral Information				
How did y □ DallasY	ou hear about ou ∕ellow Pages □	r practice? Name: Park Cities Yellow Page		Office Other:	ce Sign		

		Dental Insurand	ce Information	1	
Primary Name of Insured:				Is insured a patie	ent? ☐ Yes ☐ No
Name of Insured: Insured's Birth Date:	Last	First ID #:	MI	•	
Insured's Address:					
Insured's Employer N	lame:			State	Zip Code
Patient's relationship	Street to insured: Se	elf 🗆 Spouse 🗖 (Child Other:	State	Zip Code
Insurance Plan Name		-			
Phone #:					
Secondary (Addition	nal Insurance)			Is insured a patie	ent? □ Yes □ No
Name of Insured: Insured's Birth Date: _	Last	First			
Insured's Address:		ID #		_ Gloup #	
	Street		City	State	Zip Code
Insured's Employer N					
	Street	☐ Self ☐ Spouse	City	State	Zip Code
Insurance Plan Name	•	•			
Phone #:					
1 Hone #.					
	Minor Pa	tient's Respon	sible Party Inf	formation	
Name:		tient's Respon			
☐ Male	☐ Female	·	Relationshi	p to minor patient	
☐ Male Social Security #:	☐ Female	·	Relationshi Birth Date:	p to minor patient	
☐ Male Social Security #: Phone (Home):	☐ Female (V	Vork):	Relationshi Birth Date: Ext:	p to minor patient Best time to ca	
☐ Male Social Security #: Phone (Home):	☐ Female (V	·	Relationshi Birth Date: Ext:	p to minor patient Best time to ca	
☐ Male Social Security #: Phone (Home): Address:	☐ Female (V	Vork):	Relationshi Birth Date: Ext:	p to minor patient Best time to ca	all:
☐ Male Social Security #: Phone (Home): Address: Street	☐ Female (V	Vork):	Relationshi Birth Date: Ext:	p to minor patient Best time to ca	Apartment #
As a condition of your treatment by dental services performed without pin advance.	Female (V	Consent fo ponsible for ensuring payment on the time and the time.	Relationshi Birth Date: Ext: St ***T Services** of the full fee charged for all to exervices are performed. Page 1.0.	p to minor patient Best time to ca ate reatment performed. All emergatients who require special final	Apartment # Zip Code gency dental services, or any notial arrangements must notify us
□ Male Social Security #: Phone (Home): Address: Street City As a condition of your treatment by dental services performed without properties.	This office, the patient is respondence understand that all dental sare insurance forms or assists on the assumption that our	Consent fo Consent fo ponsible for ensuring payment of ants, must be paid for at the time services furnished are charged to time making collections from insucharges will be paid by an insuicharges will be paid by an insuicharge will b	Relationshi Birth Date: Ext: St F Services If the full fee charged for all the exervices are performed. Parance companies and will carance company. Estimates	p to minor patient Best time to ca ate reatment performed. All emergatients who require special final at he or she is personally responedit any such collections to the	Apartment # Zip Code gency dental services, or any notial arrangements must notify us used to be a patient's account. However, this
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Address: Street City As a condition of your treatment by dental services performed without pin advance. Patients who carry dental insuranc services. This office will help prepare dental office cannot render services amount due which will be determ. A service charge of 11% per montare satisfied. If my account is see	This office, the patient is respondent in the previous financial arrangements are insurance forms or assists on the assumption that our interest and billed after all insurance for this cured by credit card, I hereleved is the previous financial care can all services rendered to me, or or red, or within five (5) days of the for payment thereof. I further	Consent fo ponsible for ensuring payment of ents, must be paid for at the time services furnished are charged at in making collections from insurcharges will be paid by an insurance payments have been reunpaid balance will be charged by authorize any past due amount only be extended for a period of rat my request, by the Doctor, I billing if credit shall be extended or agree that a waiver of any bre	Relationshi Birth Date: Ext: St F Services If the full fee charged for all the services are performed. Parance companies and will carance company. Estimates are company. Estimates are company and the services are performed to the services are performed to the services are performed. If until the date of agree to pay therefore the reach of any time or condition	p to minor patient Best time to ca ate Treatment performed. All emergatients who require special final at he or she is personally respondedit any such collections to the of patient co-pay amounts are geouring card account. The patient examination. Securing card account. The patient examination. Seasonable value of said services hereunder shall not constitute	Apartment # Zip Code gency dental services, or any ncial arrangements must notify us nsible for payment of all dental patient's account. However, this e not a gaurantee of the final written financial arrangements s to said Doctor, or his assignee, shall be as billed unless objected
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