**5600 Mexico Road, Suite 20 * St. Peters, MO 63376 * 636-928-0880 * www.spencercreekdc.com**

Thank you for visiting Spencer Creek Dental Care and trusting us with your dental needs.
Please help us provide better service for you by filling out this form.

**Patient Name:** ______________________ ______________ ________ ________________
Last Name First Name Middle Initial Preferred Name To Be Called

**Address:** ______________________________ ____________________ ________
Street Town Zip code

**Telephone:** Primary(daytime): _______________ Secondary:_______________ **Email**: ________________

**Birth Date**: __________ **Gender**: M ___ F ___ **Patient (Guardian) Soc Sec #:** ________________

**Marital Status**: M S D W **Who may we thank for referring you to our office?** ____________________

PRIMARY INSURANCE CARRIER:

Subscriber's Name: ____________________Soc Sec #: ________________________ DOB:__________

Relation of Subscriber to Patient: _______________ Employer: ________________________

Dental Insurance Co: _________________________ Tel #: _______________ Group #: ___________________

SECONDARY INSURANCE CARRIER:

Subscriber's Name: ____________________Soc Sec #: ________________________ DOB:__________

Relation of Subscriber to Patient: _______________ Employer: ________________________

Dental Insurance Co: _________________________ Tel #: _______________ Group #: ___________________

## Appointment Policy

Dental appointments are reserved for each patient with enough time to complete each patient's planned treatment for each visit. The staff at Spencer Creek Dental Care may not be able to initiate treatment for patients who are late for their appointment.

We request 24 hours notice to cancel an appointment. Patients who have a combination of three late cancellations and/or not presenting for a scheduled dental appointment will be charged a $25 service fee.

## Insurance

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or family members. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or my family members and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Printed Name of Financially Responsible Party: ______________________________

Date: __________ Signature: ______________________________________