Carroll R. Butler, DDS, PA

321 West Water Street, Kerrville, TX 78028
830-257-4900 ~ www.carrollbutlerdds.com

Patient Information (CONFIDENTIAL)

Name (Last, First, Middle):_____

Birth Date:_____ SSN:_____

Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Other: _____

Mailing Address (if different from above)_____

Email:_____

Check Appropriate Box: **O** Minor **O** Single **O** Married **O** Divorced **O** Widowed **O** Separated

If Student, Name of School/College: _____City:_____ State:_____

O Full Time **O** Part Time

Patient or Parent/Guardian's Employer: _____ Work Phone:_____

Business Address: _____ City:_____ State:_____ Zip:_____

Spouse or Parent/Guardian's Name: _____ Employer:_____

Person to contact in case of emergency: _____ Phone #:_____

Other Family Members that are patients here: _____

How did you find out about us? **O** Online **O** Friend/Family _____

O Other_____

Responsible Party

Name of person responsible for this account: _____

Relationship to Patient: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Email: _____Home Phone: _____ Cell Phone: _____

Date of Birth: _____ __ SSN: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? **O** Yes **O** No

May we contact this person at work? **O** Yes **O** No

Dental Insurance Information

Name of Insured: _____

Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's SSN: _____

Employer:_____ Date Employed:_____

Address of Employer: _____ City:_____ State____ Zip Code:_____

Employer Phone: _____

Dental Insurance Company: _____

Group #: _____ Policy/ID #:_____

Ins. Co. Address: _____ City: _____ State ____

Insurance Co. Telephone #: _____

Zip Code: _____

Assignment and Release

As a courtesy to you, we can accept assignment of benefit payments from most insurance companies.
Patients who carry dental insurance understand that all services are charged directly to the patient, and that he or she is personally responsible for payment of all dental services not paid by the insurance company.

****

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: _____ (Patient or Guardian)
Date: _____