MARK X. McCARTHY, D.M.D.
PATIENT INFORMATION

Date__________

M F

Last Name First Name Middle Initial Age Date of Birth

Address Social Security Number

City State Zip ( ) Home Phone

Referred By

Single____ Married_____ Separated ____
Divorced_______ Widow/Widower_______

Occupation/Position/SELF (If Patient Is A Minor, Then Father's Name And Information) Firm Name/Address/Phone

Occupation/Position/Spouse/Life Partner (If Patient Is A Minor, Then Mother's Name and Information) Firm Name/Address/Phone

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM SELF OR PATIENT)

Last Name First Name Middle Initial Relationship To Patient

Address City State Zip ( ) Home Phone

Firm Address ( ) Firm Phone How Long at Present Employment?

"I promise to pay the amount shown to be due on each bill for services rendered within 30 days (or as otherwise agreed) after the date of said bill. If I fail to pay the amount shown to be due on any bill within 30 days or as otherwise agreed, Mark X. McCarthy, D.M.D. may recover from me and I promise to pay him his cost in collecting the amount due including a reasonable attorney's fee and court costs, if any. I also authorize Mark X. McCarthy, D.M.D. to check my credit history, if needed." You will receive monthly statements until the balance is cleared, regardless of insurance coverage or prior arrangements made.

Signature (If Minor, Responsible Party and Relationship to Patient)