Susan Mahan Kohls | DDS

Thank you for selecting our office for your dental care. To help us meet all your dental healthcare needs, please fill out these forms completely. If you have any questions or need assistance, please ask us - we will be happy to help.

Welcome

Patient Information

Date ____________

Name ____________ Birthdate ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________ Text Y/N

Email ____________

Address ____________ City ____________ State ____ Zip ____________

Patient's or Parent's Employer ____________ Work Phone ____________

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Employer ____________ Work Phone ____________ SS# ____________

Is this Person Currently a Patient in our Office? ❏ Yes ❏ No

For you convenience, we offer the following methods of payment. Please check the option you prefer.
Payment in full at each appointment. ❏ Cash Credit Card ❏ Visa ❏ MasterCard
❏ Personal Check ❏ I wish to discuss the office's payment policy

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State ____ Zip ____________

How Much is your Deductible? ____________ Calendar Year? ____________ Max. Annual Benefit ____________

Do you Have Any Additional Insurance? ❏ Yes ❏ No If Yes, Complete the Following:

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Insurance Company ____________ Group # ____________ Policy/ID # ____________

Ins. Co. Address ____________ City ____________ State ____ Zip ____________

How Much is your Deductible? ____________ Calendar Year? ____________ Max. Annual Benefit ____________