RICHARD A. MURDOCH, D.D.S.
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Glendale, CO 80246 Centennial, CO 80112
Phone: 303-355-6340 ~~ FAX: 303-355-6019
information@murdochdds.com

PLEASE PRINT DATE: ___________________

PATIENT NAME:			BIRTHDATE:
ADDRESS:			
CITY, STATE, ZIP:	EMAIL ADDRESS:	SOCIAL SECURITY #:	
PATIENT EMPLOYER:		HOME PHONE:	
BUSINESS ADDRESS:		WORK PHONE	
JOB TITLE:		CELL PHONE	

MARITAL STATUS:	SPOUSES NAME:		BIRTHDATE:
ADDRESS (IF DIFFERENT):			PHONE:
SPOUSE EMPLOYER:		SOCIAL SECURITY #:	
BUSINESS ADDRESS:			PHONE:
JOB TITLE:			

ACCOUNT INFORMATION		
RESPONSIBLE PARTY FOR THIS ACCOUNT:	RELATIONSHIP TO PATIENT:	
ADDRESS (IF DIFFERENT):		PHONE:
CITY, STATE, ZIP:	SOCIAL SECURITY #:	
PRIMARY DENTAL INSURANCE, CARRIER NAME:		
INSURANCE ADDRESS:		
POLICYHOLDER NAME:	GROUP #:	
SECONDARY DENTAL INSURANCE, CARRIER NAME:		
INSURANCE ADDRESS		
POLICYHOLDER NAME:	GROUP #:	

EMERGENCY CONTACT: ____

NEAREST RELATIVE: ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____

PAYMENT CONTRACT

I understand that I am financially responsible for the services received. Payment will be due at each appointment. Balances extending over 30 days will incur 1 1/2% per mo. unless other arrangements are made. Patient agrees to pay collection costs, including reasonable attorney's fees should the account go delinquent. A fee will be charged for appointments cancelled with less than 24 hours notice.

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SIGNATURE: RESPONSIBLE PARTY DATE