

RICHARD A. MURDOCH, D.D.S.
501 S. Cherry Street St. Suite 230 6979 S. Holly Circle Suite 185
Glendale, CO 80246 Centennial, CO 80112
Phone: 303-355-6340 ~ ~ FAX: 303-355-6019
information@murdochdds.com

PLEASE PRINT

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 a 1 1/2% finance charge per month 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.

SIGNATURE: RESPONSIBLE PARTY

DATE