

James D. Jackson D.D.S. P.C.

Savings Bank Building
Marquette

Welcome, please tell us about yourself...

Date: _____

Name: _____

I prefer to be addressed as: _____

Home Address: _____

Home Phone: _____

* Cell Phone: _____

Work Phone: _____ Ext: _____

May we contact you at this work phone? Y N Best Time: _____

* E-mail: _____

Male Female

Date of Birth: _____ Age: _____

Social Security: _____

Employer: _____ Occupation: _____

Employer Address: _____

Other Family Members at our office: _____

Whom may we thank for referring you? _____

Who was your former dentist? _____

Address: _____

Phone Number: _____ Last Visit: _____

HEALTH HISTORY ...

Physician: _____

Office Location: _____

Office Phone Number: _____

Last Visit: _____

Pharmacy: _____

Pharmacy Phone Number: _____

EMERGENCY CONTACT INFO ...

Name: _____

Relation: _____

Employer: _____

Contact Phone Number: _____

If other than yourself, please list the person responsible for the

account: _____

Billing Address: _____

Home Phone: _____

Work Phone: _____

Relationship: _____

Date of Birth: _____

Employer: _____

FINANCIAL INFO ...

Primary Ins: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Policy ID Number: _____

Group Number: _____

Secondary Ins: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Policy ID Number: _____

Group Number: _____

*I authorize release of any information relating to
claims filed by Dr. Jackson.*

Signature: _____

I wish to assign benefits to Dr. Jackson, and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature: _____