



Bruce T. Murdock D.M.D  
356 East 20 South  
American Fork, UT 84003  
801-756-4595

## Patient Information Form

*\*Please make sure to read, sign, and date the back of this form.*



Patient Full Name (First, Middle, Last)

Employer

Street Address

Is a member of your family a patient in our office?  
If so, please list their name.

  

City State Zip Code

**If filling out paperwork for your child:**

Parent/Legal Guardian

Address, if different from your child

  

City State Zip Code

  

Home Phone Work Phone Cell Phone

 

Date of Birth Social Security Number

Single  Married

Divorced  Widowed E-Mail Address



### PLEASE LIST TWO

Emergency Contact Name

Emergency Contact Name

Emergency Contact Address

Emergency Contact Address

  

Home Phone Work Phone Cell Phone

  

Home Phone Work Phone Cell Phone

**INSURANCE INFORMATION**

Subscriber's Full Name

Group/Employer's Name

Dental Insurance Company

Subscriber's ID #

Subscriber's SSN

Dental Insurance Address

Group Number

Effective Date

City

State

Zip Code

Customer Service Number

Date of Birth

**OFFICE POLICIES & FEDERAL TRUTH-IN-LENDING STATEMENT**

A payment is expected at the time of your appointment. Patients with a co-payment must pay at the time of the appointment. Patients must pay their account IN FULL at the time of service unless you set up a payment plan with our office credit manager. If you have dental insurance we will send out claim forms as a service to you to your insurance company. It is your responsibility to make sure we have all of the correct information. Patients are responsible for any balances after the insurance payment is received.

A service charge of 1.5% per month (18% annually) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for six months from the date of the patient examination.

In consideration for the professional services rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection agency commission of 40% of the delinquent balance if the account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let the office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I authorize assignments or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Bruce T. Murdock.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on the form accurately. I hereby agree to abide by the conditions outlined there in.

X \_\_\_\_\_  
Signature of Patient/Legal Guardian Date

