

Scott D. Bunday, D.D.S.

1524 Independence Pkwy., Suite A-2. Plano TX 75075 (972) 964-1032 / www.bunday.com

PATIENT INFORMATION

Today's I	Date:/		
Patient Name:First MI	 Last	Preferred Name	
Street Address:			
City:			
Social Security #://	Birth Date://	Age: Sex:M	
Home Phone #: ()	Work Phone #: () _		
Cellular Phone #: ()	Email Address:		
Emergency Contact:	Phone: ()	Relationship:	
PRIMARY DENTAL INSURANCE:			
Primary Insurance Company:	Insurer's Name:		
ID #: Grou		te of Birth//	
Patient's Relationship to Insured:Self	•		
Dental Insurance Mailing Address:			
City:	State:	ZIP:	
Dental Insurance Pl	hone #: ()		
GUARDIAN INFORMATION: (If pa	ntient is a Minor under the age of 18)		
Name of Guardian:	Relationship to F	Relationship to Patient:	
Social Security #:/	Birth Date://	Age: Sex:M _	
Home Address:			
City:	State:	ZIP:	
(Signature of Patient or Responsible 1	Party for Patients under 18 year of age)	// Date	



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PATIENT CONSENT FOR SERVICE

I give consent to any advised and necessary dental procedures, medications and/or anesthesia to be administered by the attending dentist for the purpose of dental treatment.

I understand and acknowledge that I am **FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED** for myself of the above named, regardless of INSURANCE COVERAGE.

I understand and acknowledge that Scott D. Bunday, D.D.S. will only accept assignment of benefits on my PRIMARY INSURANCE COVERAGE and that I am responsible for any SECONDARY INSURANCE filings.

I understand and acknowledge that I am responsible for the copayment of dental services rendered on the day of the services, unless other financial arrangements have been established.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Scott D. Bunday, D.D.S.

I grant my permission to you or your assignee, to telephone me at home, work or cellular to discuss matters related to this form.

Release of Information: I authorize Scott D. Bunday, DDS to release information requested by my dental insurance, in order to assist in payment of claims.

I have read the above conditions of treatment, release of information and payment agreement statement and agree to the their consent.

	/ /
(Signature of Patient (Responsible Party for Patients under 18 year of age)	Date