GillespieDentistry
Smile With Confidence

13200 SE McGillivray
Vancouver, WA 98683
Phone: 360-892-6132
Fax: 360-892-0297
Email: team@gillespiedentistry.com

Date _____

Last Name _____ First Name _____ Initial _____ Birthday _____ SSN _____

Address _____ City _____ State ____ ZIP _____

Home Phone _____ Business Phone _____ Cell Phone _____

Sex: M☐ F☐ Marital Status: M☐ S☐ Driver's License# _____ Email _____

Employer _____ Occupation _____

Emergency Contact _____ Address _____ Phone _____

Whom may we thank you for referring you? _____

Subscriber's Last Name _____ First Name _____ Initial _____

Relation to Patient _____ Birthdate _____ Phone _____ Subscriber's SSN_____

Subscriber's Address _____ City _____ State ____ ZIP _____

Subscriber's Employer _____ Occupation _____

Insurance Company _____ Address _____

Phone _____ Group Number _____ ID Number _____

Other dependents covered under plan _____

Patient covered by additional insurance? Yes No Subscriber Name _____

Relation to Patient _____ Birthdate _____ Phone _____ Subscriber's SSN_____

Subscriber's Address _____ City _____ State ____ ZIP _____

Subscriber's Employer _____ Occupation _____

Insurance Company _____ Address _____

Phone _____ Group Number _____ ID Number _____

I understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Gillespie Dentistry of the group benefits otherwise payable to me. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses. Including reasonable attorney fees. **I understand that there may be a *$50* charge assessed on all accounts for appointments missed or cancelled without 48 hours notice.** I hereby authorize the doctor to release information necessary to secure payment of benefits. I hereby authorize Gillespie Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient Signature _____ Date _____

(If patient is a minor, Parent/Guardian Signature)

Signee Name _____

(Please Print)