EPPERSON PAYNE
DENTAL GROUP

8220 Memphis Avenue • Lubbock, Texas 79423
P: 806.745.1745 • www.eppersonpaynedental.com

Patient Information

Patient Name:_____ _____ _____ _____
Last First MI Preferred Name

❑ Male ❑ Female ❑ Adult ❑ Child ❑ Married ❑ Single

Birth Date:_____ SS#:_____ Driver's License #/State:_____

Email Address:_____

Phone:_____ _____ _____
Mobile Home Work

***Please let us know if you do NOT want to be reminded of your appointment via text or email.**

Address:_____

_____ _____ _____
City State Zip

Referred By

Who referred you to our office:_____

Emergency Contact

Name:_____ Relationship:_____

Telephone:_____

Person Responsible for Payment

The following is for:

❑ Self ❑ Other: Relationship to Patient:_____ ***Must sign Truth-In-Lending Statement (pg.2)**

Name:_____ _____ _____
Last First MI

Birth Date:_____ SS#:_____ Driver's License #/State:_____

Email Address:_____

Phone:_____ _____ _____
Mobile Home Work

Address:_____

_____ _____ _____
City State Zip

Dental Insurance Information

Is the subscriber a patient? ❑ Yes ❑ No Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Name of Subscriber:_____ _____ _____
Last First MI

Birth Date:_____ Subscriber's SS#:_____

Subscriber's ID#:_____ Group#:_____

Subscriber's Address:_____

_____ _____ _____
City State Zip

Subscriber's Employer Name:_____

Insurance Plan Name:_____

Insurance Phone:_____

Are you covered by two Dental Insurance Policies? ❑ Yes ❑ No

Is the Secondary Subscriber a patient? ❑ Yes ❑ No Relationship to Patient: ❑ Self ❑ Spouse ❑ Child

Name of Secondary Subscriber:_____ _____ _____
Last First MI

Secondary Subscriber's Birth Date:_____ SS#:_____

ID#:_____ Group ID#:_____

Insurance Plan Name:_____ Insurance Phone:_____

Truth-In-Lending Statement

As a condition of my treatment by Epperson Payne Dental Group, financial arrangements must be made in advance.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for at the time services are rendered.

Patients who are insured through a dental policy understand that our practice is not partnered with any insurance companies. However, our practice will help file the patient's insurance forms and assist in collecting from insurance companies. Our practice cannot guarantee that the services rendered to the patient will be covered by insurance. I, the patient, am personally responsible for payment of all dental services rendered should insurance not cover the fees.

I undstand that the treatment estimates for dental care can only be extended for a period of six months from the date of consultation.

I agree to pay the charges for the services rendered at the time of treatment. I further agree that my account may be turned over to a collection agency as a result of non-payment for treatment rendered.

Person Responsible for Payment Signature:_____ Date:_____