Patent Pending
RECORDAFAX™
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PATIENT INFORMATION (Please Print)

Name ____________________ (Last, First, Middle) (Nickname)

Address ____________________

City __________ State ______ Zip __________

Email __________ Phone (H) __________

Employer __________ Phone (W) __________

Address ____________________

Date of Birth ________ Present Age ____ Cell Phone __________

Male ☐ Female ☐ Soc. Sec. # __________

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Number of Children ________ Previous Dentist __________

PERSON RESPONSIBLE FOR ACCOUNT

Name __________ Relationship __________

Address ____________________

City __________ State ______ Zip __________

Employer __________ Birth Date __________

Soc. Sec. # __________ Drivers Lic.# __________

Spouse's Name ____________________

Address ____________________

City __________ State ______ Zip __________

Employer __________ Birth Date __________

Soc. Sec. # __________ Drivers Lic.# __________

PAYMENT WILL BE MADE BY

☐ Cash ☐ Check ☐ Credit Card

DO NOT WRITE BELOW THIS LINE

MEDICAL ALERT

Allergies __________ __________

Precautions __________ __________

Premedication __________ __________

Nitrous Oxide ☐ Yes ☐ No

☐ Nasal Inhaler Minute Vol. ______ N20 ______ 02 ______ LF/M

☐ Cannula N20 LF/M __________

DENTAL INSURANCE

Name __________ Phone # __________

Primary ____________________

____

Secondary ____________________

____

IN CASE OF EMERGENCY CONTACT

Name Nearest Relative ____________________

Address __________ Phone __________

Other ____________________

YOUR FAMILY PHYSICIAN IS __________

WHO REFERRED YOU TO OUR OFFICE

Name __________ Relationship __________

Address ____________________

AUTHORIZATION (Please read the following information carefully)

I grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary.

I/we agree to pay a finance charge of _____ % per month (an annual rate of _____ %) on the unpaid balance after _____ days and up to _____ % of collection costs and/or attorney's fee up to _____ % if any delinquent balance is placed with an agency or attorney for collection or suit. Patient Initial _____

I/we hereby authorize release of any information relating to dental treatment and dental claims. I/we agree to be responsible for payment of services not covered by insurance.

I hereby authorize payment of all dental insurance benefits directly to
Jimmy F. Maxwell, DMD, PC (Dentist)

Authorized Signature __________ Date __________

DO NOT WRITE BELOW THIS LINE

REMARKS ____________________

____

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