Scott M. Blake, D.D.S., P.C.

Oral & Maxillofacial Surgery

333 S. Woodruff

IDAHO FALLS, ID 83401

(208) 523-2160

Patient Information

Date :___________

Name: _______________________________________ Age: ________Married Single Male Female
Last First M

Address: ____
Street apt# City State Zip

Birthdate: _______________________Telephone: ____
Mo Day Yr Home# Work #

Employment (or School): _________________________Occupation: ___________SS# ______________

Dental Insurance Co: ____Group # ____________

Has any member of your family ever been treated in our office ? ______Yes ______No

Whom may we thank for referring you to our office?

Family Information

Father or Husband
Name: ____ Address: ____________________________
Last First M Street City State Zip
Telephone: _______________________________________Birthdate: _______________SS# __________
Home # Work or Cell # Mo Day Yr
Employer: ____Dental insurance Co: _____________________
Employer Occupation Group

Mother or Wife
Name: ____ Address: ____________________________
Last First M Street City State Zip
Telephone: _______________________________________Birth date: _______________SS# __________
Home # Work or Cell # Mo Day Yr
Employer: ____Dental insurance Co: _____________________
Employer Occupation Group

Person Responsible for this Account:_________________________

Method of Payment

Does Responsible Party currently have an account with this office? ________
____Payment in full at each appointment ____Credit Card M.C. or VISA _____ Insurance and balance in cash

Finance Charge. If I do not pay the entire New Balance within 90 days of the monthly billing date, a Finance charge will be added to the account for the current monthly billing period. The Finance Charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00) which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

Name of person to contact outside of immediate family in case of emergency; Name: ______________________________________
Last First
Address ____Telephone: _______________
Street City State Zip

I hereby authorize payment directly to Scott M. Blake, D.D.S., P.C. of the group insurance benefits otherwise payable tome. I understand that I am responsible for all costs of dental treatment. The information on this page and the medical history are correct to the best of my knowledge.

____ Date ________________
Adult Patient ___ Father ___Husband ___Mother ___Wife ___ Guardian