

Liza King D.M.D.
Patrick F. Carroll D.M.D
400 Central Avenue
Dover, NH 03820

PATIENT INFORMATION:

Patient Name _____ Gender: M or F
Date of Birth _____ Social Security # _____
Address _____
City, State, Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____
Employer _____
Dentist Preference: _____ Dr. King _____ Dr. Carroll _____ No Preference

DENTAL INSURANCE INFORMATION

Primary Insurance _____
Group # _____ ID# _____
Name of Subscriber _____ Date of Birth _____
Employer _____
PO Box Address to Send Claims to: _____
Relationship to Patient: Self _____ Spouse _____ Parent/Guardian _____

PARENT/GUARDIAN INFORMATION (IF APPLICABLE)

Name _____
Date of Birth _____ Social Security # _____
Employer _____

Payment is expected at the time of service. As a courtesy, we will submit claims on your behalf to the insurance company. We accept cash, check, and credit cards.

SIGNATURE of patient and/or guardian Date
PLEASE HAND INSURANCE CARD TO RECEPTIONIST

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices from the office of Dr. Liza King & Dr. Patrick Carroll, which sets forth the ways in which my personal health information may be used or disclosed by this office and outlines my rights with respect to such information.

Print Name

SIGNATURE Date