Accord Dental, P.C
1-A Hawthorne Road
North Grafton MA 01536
508-839-6464

Patient's Name: _____ Birthdate: ___/___/___ Sex: M F
Address: _____ Apt#: _____ Martial Status: S M D
City: _____ State: _____ Zip: _____
SS#: ___-___-____ Home Phone: (____)____-____ Work Phone: (___)____-____
Cell Phone (____)____-____ Email Address: _____

If you are a full time student what school are you enrolled in? _____

Employer's Name: _____ Occupation: _____

How did you hear about our office? _____

Name(s) of any other family member(s) seen in our office: _____

Person Responsible for this Account
Relationship to Patient ☐Self* ☐Spouse ☐Parent/Guardian * If self, skip to **Insurance Section**
Name: _____ Birthdate: ___/___/___ Sex: M F
Does this person & patient reside in the same household? ☐YES ☐NO If NO please write info below
Address: _____ Apt#: ____ Home Phone: _(___)____-____
City: _____ State: _____ Zip: _____ Work Phone: _(___)____-____
SS#: ___-___-____
Employer's Name: _____ Occupation: _____

Is Patient Covered By Dental Insurance? ☐YES ☐NO
Employee's Name: _____ Birthdate: ___/___/___ Sex: M F
SS# or Subscriber Number (shown on card) _____
Employer's Name: _____ Insurance Company:
_____
Relationship to patient: ☐Self ☐Spouse ☐Parent/Guardian Group#: _____
Is patient covered by another dental insurance? ☐YES ☐NO

Secondary Dental Insurance
Employee's Name: _____ Birthdate: ___/___/___ Sex: M F
SS# or Subscriber Number (shown on card) _____
Employer's Name: _____ Insurance Company:
_____
Relationship to patient: ☐Self ☐Spouse ☐Parent/Guardian Group#: _____
Is patient covered by another dental insurance? ☐YES ☐NO

NOTE: Due to the constantly changing insurance rules and regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected you will be credited the difference. If your insurance company pays less than expected you will be billed the difference. Final responsibility for payment rest with the person responsible for your account.

Date: __/__/____ Signature: _____ Relationship to Patient: _____