Jason T. Lipscomb D.D.S.

PATIENT PROFILE

Name:	SSN:	Date Of Birth / /
What would you like to be called:		
Spouse's Name:	SSN:	
Address:		Zip:
Home Phone:	Work Phone:	
Cell Phone:	E-Mail Address:	
Employed By:	Spouse Employed By:	
Emergency Contact:	Relation:	Phone:
Person Responsible for Account:		
Relationship:	SSN:	
Insurance Company:	Policy Holder:	

Whom may we discuss your account with? _____

How did you learn of our practice? _____

How do you feel about going to the dentist? ☐ Fear ☐ Comfortable

When was your last dental exam, cleaning, x-ray, etc? _____

Why did you leave the last dentist? _____

If you could change anything about your smile, what would it be? _____

I certify that I have read the above statements and have completed the information truthfully and correctly. I have read and understand the payment options provided for me. I also understand that Jason T. Lipscomb D.D.S. is a member of Equifax Credit Services and that they may at their discretion check and verify my credit, employment, and salary histories and secure follow-up credit reports concerning my credit worthiness. Upon signing below, I authorize them to do so.

Contract Covering Terms of Payment: (Please see payment options for more information)

Jason T. Lipscomb D.D.S. requests that payment arrangements be established before your dental services are provided. Time payment plans will carry a finance charge within the limits prescribed by State law. A late charge will be added If the account is not paid within 10 days of due date. In extended payments, a finance charge of 1½% per month will be added after 60 days.

Default on payment will subject the account to all collection fees, including but not limited to court costs and 33⅓% attorney fees, whether or not court proceedings are necessary, that may be incurred on enforcing the doctor's rights under this agreement or under any law of this State. This contract is binding for current and future transactions.

_____

Signature Date

Privacy Policy Notice

I acknowledge that I have received and reviewed the Privacy Policy for Jason T. Lipscomb D.D.S.

Patient's Name:_____ Signature:_____

Reason for Refusal:_____

Privacy Policy Director's Signature:_____