

● *Welcome*

Sandra E Slater DDS

General, Implant, & Cosmetic Dentistry
228 Wesley Dr. Kerrville, Texas 78028
830-257-2060
Sesdds2@windstream.net
www.MyKerrvilleDentist.com

● Patient Information

Please check if patient is a minor/child

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone / Home: _____ Work: _____ Cell: _____

Sex: Male Female Employer: _____ E-mail address: _____

Marital Status: Married Divorced Separated Single Widowed

Birth Date: _____ Soc Sec #: _____ Drivers Lic: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ phone: _____

● Responsible Party Information (If you are responsible for yourself - please skip)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone / Home: _____ Work: _____ Cell: _____

Birth Date: _____ Soc Sec #: _____ Drivers Lic: _____

Relationship to patient: _____

● Payment Policy

Payment in full is expected at time of service. If you require extensive dental treatment, we have several options that may fit your needs, including Capitol One Healthcare Finance.

Please indicate how you will be paying today's services:

Cash Check Visa MasterCard American Express Discover.

● Insurance Policy

Do you have dental insurance coverage? Yes No

Did you provide us with a copy of both sides of your insurance card prior to your appointment? Yes No

As a courtesy to you we file your insurance claim electronically and accept assignment of benefits. In the event your insurance company does not make payment in a reasonable time, or does not pay the estimated portion, you will be responsible for the balance. We do not participate in PPO plans.

● Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners.

Signature of patient (or parent if minor) _____ Date: _____