Bushnell Family & Cosmetic Dentistry

Sumter Value Dental

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent

Patient Name: ______________________ ______________________ _____ ____________________
Last First MI Preferred

Title: ___________ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: _________ SS # __________________ Email Address: _________________________________

I consent to be contacted via: (check any) ☐ Text Messages ☐ Email ☐ Phone Call/Voicemail

Phone: _________________ _________________ _________________ _________________________
Home Cell Work Other

Address:____

_________________________________ _______________ ___________________
City State Zip Code

Please list any family/friends that we may discuss treatment, finances or reference appointments with:
____
____

Whom may we thank for referring you to our practice?
☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School
☐ Work ☐ Insurance ☐ Other: ____

Emergency Contacts:

____ ____
Name Phone
____ ____
Name Phone

Insurance Assignment of Benefits Release

By signing below, I acknowledge all insurance benefits, if any, will be paid to Bushnell Family & Cosmetic Dentistry or Sumter Value Dental. I understand that I am financially responsible for all charges whether or not paid by insurance.

____ ____
Signature Date

Relationship to patient:
☐ Self ☐ Parent ☐ Guardian ☐ Other ___________________________________