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

PATIENT INFORMATION:
Patient Name_____
Date of Birth_____ Social Security #_____
Address_____
City, State, Zip Code_____
Home Phone_____ Cell Phone_____ Work Phone_____
Email _____
Employer_____
Dentist Preference: _____ Dr. Karelitz _____ Dr. King _____Dr. Carroll _____ No Preference

PARENT/GUARDIAN INFORMATION
Name_____
Date of Birth_____ Social Security #_____
Employer_____

DENTAL INSURANCE INFORMATION
Primary Insurance_____
Group #_____ ID#_____
Name of Insured_____ Date of Birth_____
Employer_____
Employer Address_____
Relationship to Patient: ____Self ____ Spouse ____Parent/Guardian

Secondary Insurance_____
Group #_____ ID#_____
Name of Insured_____ Date of Birth_____
Employer_____
Employer Address_____
Relationship to Patient: ____Self ____ Spouse ____Parent/Guardian

FINANCIAL POLICY
Individual responsible for account balances _____
Relationship to Patient _____
Address _____ Phone_____
City, State, Zip Code _____

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.

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