J. STEPHEN WEIR. D.D.S

PRACTICE LIMITED TO PERIODONTICS
5348 Estate Office Drive
Memphis, Tennessee 38119
Phone: 901-763-4700
Fax: 901-763-4794

PATIENT INFORMATION

First Name:_____ Middle Initial:_____
Last Name:_____
Preferred Name:_____
Address:_____
_____
City, State, Zip:_____
Home Phone:_____
Work Phone: _____
Cell Phone: _____
Alternate Phone/Pager:_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Date of Birth:_____ Sex: ☐ Male ☐ Female
Age:_____ SSN:_____

Drivers License #:_____
Email:_____
Referring Dentist / Person :_____
Referring Dentist Phone:_____
General Dentist: _____
General Dentist Phone:_____
Preferred Pharmacy:_____
Preferred Pharmacy Phone:_____
Emergency Contact:_____
Emergency Contact Phone: _____
Emergency Contact Relationship:_____

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Unemployed ☐ Retired ☐ Other:_____
Occupation:_____

Employer Name:_____
Employer Phone: _____

RESPONSIBLE PARTY (only if patient is under 18 years of age)

Name:_____
Address: _____
_____
City, State, Zip:_____
Date of Birth:_____ SSN:_____
Relationship to Patient:_____

Home Phone: _____
Work Phone:_____
Cell Phone:_____
Email:_____
Drivers License #: _____
Employer Name:_____

PRIMARY DENTAL INSURANCE INFORMATION

Policyholder Name:_____
Policyholder Address:_____
_____
City, State, Zip:_____
Date of Birth:_____ SSN:_____
Relationship to Patient:_____
Insurance Co. Name: _____
Insurance Co. Phone:_____
ID#:_____
Group #: _____
Employer Name:_____

SECONDARY DENTAL INSURANCE INFORMATION

Policyholder Name:_____
Policyholder Address:_____
_____
City, State, Zip:_____
Date of Birth:_____ SSN:_____
Relationship to Patient:_____
Insurance Co. Name: _____
Insurance Co. Phone:_____
ID#:_____
Group #: _____
Employer Name:_____

Please present your insurance card to the receptionist

Certification: I certify that the answers given are correct to the best of my knowledge.
Assignment, Release & Responsibility: I hereby authorize insurance payment of dental benefits directly to Dr. Weir. I also authorize the release of information acquired in the course of my examination & treatment. I understand that I am financially responsible for services not covered by insurance & should my bill become delinquent, I am responsible for billing fees, collection costs, attorney fees and court costs.
Medicare: I understand that neither Dr. Weir, nor I can file Medicare claims for services in this office.
No-Show & Late Cancellations: I understand that no-show appointments & cancellations with less than 48 business hours notice are subject to a late cancellation fee.

Signature:_____ Date_____
(Parent or guardian to sign if patient is under 18 years of age)