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Wilmington, NC 28401

Telephone (910) 762-0786

HOME PHONE _____ CELL PHONE _____ REFERRED BY _____

PATIENT: _____
LAST NAME FIRST NAME MIDDLE INITIAL NICK NAME

ADDRESS: _____
(PLEASE LIST STREET AS WELL AS P.O. BOX) STREET P.O. BOX CITY STATE ZIP

SEX: MALE FEMALE AGE: _____ BIRTHDATE: ___/___/___

MARITAL STATUS: MARRIED SINGLE DIVORCED SOCIAL SECURITY# ___/___/___

PATIENT'S EMPLOYER: _____ PHONE: _____

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____ PHONE: _____

SPOUSE'S SOCIAL SECURITY # ___/___/___ SPOUSE'S BIRTHDATE ___/___/___

IF PATIENT IS A CHILD

MOTHER'S NAME: _____ SOCIAL SECURITY# ___/___/___

FATHER'S NAME: _____ SOCIAL SECURITY# ___/___/___

ADDRESS: (IF DIFFERENT FROM ABOVE) _____
STREET P.O. BOX CITY STATE ZIP

PHONE: (IF DIFFERENT FROM ABOVE) _____

MOTHER'S EMPLOYER: _____ PHONE: _____

FATHER'S EMPLOYER: _____ PHONE: _____

INSURANCE INFORMATION

NAME OF DENTAL INSURANCE COMPANY: _____

ADDRESS TO MAIL CLAIMS: _____

SUBSCRIBERS NAME : _____ RELATIONSHIP TO PATIENT: _____

I.D. NUMBER: _____ SUBSCRIBERS BIRTHDATE ___/___/___

How will this account be handled today:
CASH CHECK BANK CARD

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize treatment by Dr. & Dr. Morris and release any and all medical information for the purpose of insurance and/or dental benefits payment. I hereby authorize insurance benefits to be paid directly for dental or surgical treatment to Drs. Kenny and/or Victoria Morris.

SIGNATURE: _____ DATE: _____