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Phone 503 640-0395

Welcome to Our Practice!

Thank you for selecting our dental healthcare team! We will constantly strive to provide you with the best possible dental care.

Patient Information

Patient's Name _____ Name Preference _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Date of Birth _____
Employer _____ Social Security # _____
Address _____ Business Phone _____

Person to contact for emergency _____ Relationship _____ Phone _____
Other family members who are patients in our office _____
Whom may we thank for referring you to our office? _____

Responsible Party Information (If different than above.)

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Date of Birth _____
Employer _____ Social Security # _____
Address _____ Business Phone _____

Dental Insurance Information

Dental Insurance Co. _____ Effective Date _____
Address _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Date of Birth _____
Social Security # _____ Group # _____
Maximum annual benefit \$ _____ Deductible \$ _____ Amount already used this year \$ _____

Secondary Insurance Co. _____ Effective Date _____
Address _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Date of Birth _____
Social Security # _____ Group # _____
Maximum annual benefit \$ _____ Deductible \$ _____ Amount already used this year \$ _____

I hereby authorize payment of benefits directly to the provider and the release of all necessary information to the insurance carrier.

Signature of the Insured _____ Date _____