WALTER H. SMITH, JR., D.M.D.
WILLIAM E. WRIGHT, D.M.D., P.C.

205-759-2811; Fax 205-759-2979
6541 Highway 69 South Suite B
Tuscaloosa, AL 35405

Date_____

Name_____ Birth Date_____

Address_____City/State_____Zip_____

Telephone Home_____Work_____Cell_____

Preferred Name_____

Marital Status_____Social Security #_____E-mail address_____

Employed by_____Occupation_____

Emergency Contact_____Relationship_____Phone_____

Students:School_____Major_____ Graduation Yr_____

Name of Spouse/Parent_____

Address (if different from above)_____

How did you hear about us?_____ Referred by_____

Do you have Dental Insurance? Yes_____ No_____ If yes:

Name of Policy Holder_____ Relationship _____

Name of Policy Holder's Employer_____

Date of Birth of Policy Holder_____

Policy ID# _____Group #_____

Name of Dental Insurance Co._____ _____

Address of Insurance Co._____

City_____ State_____ Zip Code_____

Please list all family members covered under this policy_____

_____

I authorize release of any information relating to dental claims. I understand that I am responsible for all costs of dental treatment, regardless of insurance coverage, on the day of service unless other arrangements have been made prior to the start of treatment. There will be a monthly finance charge of 1.5% (18%APR) for all unpaid balances over 60 days. By signing below, I acknowledge that I have read the Notice of Privacy Practices and have been given the opportunity to keep a copy of the notice.

Signature of Patient (Parent if Minor)_____