Sullivant Dentistry

You Deserve A Sullivant Smile

Name: _____ **DOB:** _____ **SS#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

PRIMARY DENTAL INSURANCE CARRIER: _____

If YOUR SPOUSE is the Insurance Carrier, please provide their information:

Name: _____ **Employer Information:** _____

Spouse DOB: _____ **Spouse SS#:** _____

If you have Secondary Dental Insurance, please provide that card information:

_____

We do NOT accept ARkids, MEDICAID or MEDICARE -- EXCEPT FOR THE DELTA DENTAL WELL CARE program.

Please provide your E-MAIL ADDRESS: _____

Please tell us how you heard about Sullivant Dentistry: _____

Mark the box that applies: [ ] Minor [ ] Single [ ] Married

Signature of the person responsible for minor patient: _____

Our fees are the same if a patient has insurance or is self-pay.

We DO NOT have an IN-OFFICE payment Plan.

I UNDERSTAND I AM REQUIRED TO PAY IN FULL for my services received today -- (even if I have Dental Insurance, I must pay for my estimated percentage at each appointment).

Emergency Contact:

Name:_____**Phone:**_____

OUR MISSION STATEMENT

To provide our patients the highest quality care in a safe, efficient and comfortable environment.

The information that I have given today is correct to the best of my knowledge. I also understand it is my responsibility to inform this office of ANY changes in the future. I authorize Dr. Sullivant (and his staff) to perform any necessary dental services, such as x-rays, study models, photographs or any other diagnostic aide to assist in my dental care.

SIGNATURE:_____**DATE:**_____