■ □ ■ □ ■ Robert B. Shelton, D.D.S. ■
■ □ ■ □ 905 Walnut Hill Drive, Suite 1 ■ □
■ □ ■ Longview, Texas 75605 ■ □ ■
■ □ (903)757-6243 ■ □ ■ □
■ ■ □ ■ □ ■

Name: ____ Birth date: _______/______/________
(Last, First, Middle initial)

Age: __________ Home Phone: (_____)________________________ Sex: O Male O Female

Address: _______________________________________ City: ______________________________________

State: ________________________ Zip: ______________ Mobile Phone: (____)____________________

Business Phone: (_____)_____________ Social Security # ________/________/___________

Occupation: ________________________ Employer Name:____

Status: O Married O Single O Divorced O Widow/Widower/ Home Phone (__)___________________

Relationship to person responsible for payment: O Self O Spouse O Child O Other

Person to contact in case of emergency: ____

Home Phone :(_____)____________________ Business Phone: (_____)__________________________

Relationship: ______________________ Address: ____

City: ________________________________ State: _______________________ Zip: __________________

How did you hear of Dr. Shelton? O Friend or relative: ____

O Phonebook/yellow pages O Other (describe): ____

Information about responsible party:

Name: ____ Home Phone: (_____)_________________
(Last, First, Middle Initial)

Address: ____ City: __________________________________

State: _______________________ Zip: ________________ Social Security # _______/______/___________

Birth date: _______/_______/_________ Employer Name: ____

Business Phone: (_____)________________________

I authorize Robert B. Shelton, D.D.S. to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF DENTAL SERVICES ON THE DATE THAT THE SERVICE IS PERFORMED.

Signature: ____ Date: ____