Kenny J. Morris, Jr., D.D.S.
Victoria R. Morris, D.D.S.
2252 Yaupon Drive
Wilmington, NC 28401

Telephone (910) 762-0786

HOME PHONE ____________ CELL PHONE ____________ REFERRED BY ____________

PATIENT: ____
LAST NAME FIRST NAME MIDDLE INITAL 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: ______________