Dr. Terrance L. Ware, DDS

5800 Ridgewood Rd, Ste 104 Jackson, MS 39211
T: (769)251-5909 F: (769)524-3344
waredentalpllc@gmail.com

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: Street _____

City _____ State _____ Zip _____

Contact Info: Home _____ Cell _____ Work _____

E-mail _____ Social Security # _____

Medical Doctor _____

Employed By: _____

Employer's Address: _____

Who referred you to our office or How did you find us? _____

BILLING INFORMATION

Name of Person Responsible for Account: _____

Date of Birth: _____ Phone #: Home _____ Work _____

Address: Street _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____

Employed By: _____

Address: _____

I understand that I am personally responsible for my dental bill. I also understand that in default of payment where the debt is placed in the hands of a collector or an attorney for collection, all collection fees, costs, and all other expenses will be paid by me. I understand that the insurance forms are filed by this office as a courtesy and that my insurance carrier will pay my dentist directly for expenses incurred. I understand that insurance payment is not guaranteed and payment will be determined by insurance at the time the claim is submitted. All dental fees are payable at the time of my visit.

Date: _____ Signature: _____ Relationship: _____