MICHAEL D. IRWIN, D.M.D.

Diplomate of the American Board of Dental Sleep Medicine
4162 Lomac Street, Montgomery, AL 36106

NEW PATIENT INFORMATION (PLEASE PRINT)

Patient's Full Name: _____

Date of Birth: _____ Age: _____ SS#: _____ Driver's License #: _____

Sex: _____ Race: _____ Single/Married/Divorced/Widowed (Circle One)

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Insurance: _____

Employer: _____

Address: _____

Patient's Dentist: _____

Referring Physician: _____

Spouse or Parent's Name (Circle) _____

Date of Birth: _____ SS#: (if needed for insurance)_____

Work #: _____ Cell #: _____

Spouse's Employer _____

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

You agree, in order for us to service your account or to collect monies you may owe, Michael D. Irwin, PA and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Michael D. Irwin, PA, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature Date