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_____ Preferred Name _____

Birth Date _____/_____/ _____ Age: _____ Male_____ Female_____ Race _____

SS# _____ Single/Married/Divorced/Widowed (Circle One)

Address _____ City _____ State ___ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Insurance _____

Employer _____ Address _____

Referring Physician _____Patient's Dentist _____

Spouse or Parent's Name (Circle) _____

Spouse/Parent Birth Date _____ SS# (if needed for insurance)_____

Spouse/Parent Phone _____ Spouse's Employer _____

In case of emergency call _____ Phone _____

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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