H.J.Turner III, D.D.S., M.S.

Pediatric Dentistry of Spartanburg & Gaffney

D. Jensen Turner, D.M.D.

Patient Information			
Last Name		First Name	
Middle Initial		Preferred Name	
Street Address		Birth Date	
City		Sex (M/F)	
State		Zip	
Social Security #			
Cell Phone		Secondary Phone	
Email			

Guarantor Information (Person Responsible for Bill)			
Last Name		Social Sec. #	
First Name		Birth Date	
Middle Initial		Sex (M/F)	
DL #			
Street Address			
Cell Phone		Secondary Phone	
City		State	Zip Code
Email			
Guarantor Employment Information			
Employer Name		Employer Phone	
Street Address		Suite/Apt#	
City		State	
Zip Code		County	

Insurance Information for Patient - Provide Complete or provide copy of insurance card		
Insurance Company #1	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:
Insurance Company #2	Policy #	Name of Insured:
	Group #	SSN:
	Relationship to Insured:	Birthday of Insured:

Signature of Patient/Guardian: _____