

Scott Young, D.D.S.  
Cosmetic & Reconstructive Dentistry  
6769 Lake Woodlands Dr., Suite G, The Woodlands, TX 77382  
281.367.5559 / 281.465.8737 facsimile

**GUEST INFORMATION (Please Print)**

Date: \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_  
First MI Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Prefer appt. confirmation via email? \_\_\_\_\_

SS# \_\_\_\_\_ Circle One: Minor Single Married Divorced Widowed

How did you hear about Dr. Young? \_\_\_\_\_

If guest is a student, name of school or college \_\_\_\_\_ PT or FT

If guest is a minor: Parent's Name \_\_\_\_\_ SS# \_\_\_\_\_

Guest's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**RESPONSIBLE PARTY (If different from above)**

Name of person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_

SS# \_\_\_\_\_ Name of Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Phone# \_\_\_\_\_

**FINANCIAL POLICY**

I have read and agree to the financial policies of this office.

\_\_\_\_\_  
Signature Date: \_\_\_/\_\_\_/\_\_\_