

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Personal Information

Please provide us with your email and cell phone numbers. We do not share this information.

Name: _____ S.S #: _____

Address: _____ E-mail Address _____

City: _____ State: _____ Zip: _____ Fax # _____

Telephone: (H) _____ (W) _____ (Cell/Pager) _____

Birth Date: _____ Age: ____ Sex: M F Marital Status: _____ Spouse Name: _____

Employer: _____ Occupation: _____

Whom May We Thank For Referring You: _____

Is Another Member Of Your Family, Or Relative, A Patient At Our Office? Yes No

Their Name: _____

Person To Contact For Emergency: _____ Phone: _____

Address: _____

Street

City

State

Zip

Closest Relative Not Living With You: _____ Phone: _____

Address: _____

Street

City

State

Zip

Person Responsible For Account

Name: _____ Relationship: _____ S.S. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (H) _____ (W) _____ (Cell/Pager) _____

Dental Insurance Information

Insurance Company: _____

Address: _____

Street

City

State

Zip

Employee: _____ Date of Birth: _____ S.S. #: _____

Employer: _____ Policy #: _____ Relationship To Patient: _____

I understand that payment is my obligation regardless of insurance or any other third party involvement and that payment is due at the time of service unless other arrangements have been made in advance. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account.

Signature:

Date: