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Patient Information Form

Name ____________________________________ Age _________ Birth date ________ Sex _______
Last First Initial
Social Security # ________________________________ Driver's License _____________

Home Address __________________________________ City _________________ State ___ Zip __________

Home Phone ____________________ Cell Phone ______________ E-mail Address: _____________

Employer ___________________________Occupation ___________________ Marital Status ______

Whom may we thank for referring you to us? ______________________ **Phone** _________________

Primary Dental Insurance: __________________ Name of the subscriber ________________________

Employer _______________ Birth date ___________ Social Security # ___________________________

Secondary Dental Insurance: __________________ Name of the subscriber ______________________

Employer _______________ Birth date ___________ Social Security # ___________________________

Who should we contact in case of an emergency :
Name ______________________________________ Relationship ______ Phone ___________________
Last First Initial

Patient's portion (co-payment) is due at the day of service.

Missed appointments
Please help us serve you better by keeping scheduled appointment. Unless canceled, at least 48 hours in advance, our policy is to charge for non-emergency missed appointments at the of normal office visit ($50.00 per ½ hr).

Returned checks
All returned checks are subject to $50.00 service charge that will be added to your account balance.

The goal of our office is constantly strive to provide you with the best dental care available today. We are proud of the quality of services that we provide and we are open to suggestions. However, in case of any grievance, the patient or patient's responsible party agrees to pay all cost and reasonable attorney fees if suit were instituted hereunder.

I agree that the any treatment or charges will be sent to my insurance company and that in any case, my insurance did not or partially paid the amount, I will be responsible for the full or remaining balance. I also authorize release of any information relating to this claim.

Patient/Parent/Guardian Signature ________________________________ **Date** __________________