

WELCOME TO OUR PRACTICE

INFORMATION ON PATIENT:

HAVE YOU BEEN A PATIENT OF OUR PRACTICE? _____ **IF YES – WHEN?** _____

(Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Preferred Name _____ Sex: M F Date of Birth _____ Age _____

Are you: _____ Single _____ Married _____ Divorced _____ Legally Separated _____ Widowed

Social Security # _____

Home (Mailing) Address _____ Apt # _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Work Phone (_____) _____ Other Phone (_____) _____

Student Status: _____ Full Time _____ Part Time Name of School _____

Employment Status: _____ Full Time _____ Part Time _____ Not Employed _____ Retired

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION:

_____ Father _____ Mother _____ Spouse _____ Guardian _____ Other (What is Relationship? _____)

(Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Social Security # _____

Home (Mailing) Address _____ Apt # _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Work Phone (_____) _____ Other Phone (_____) _____

Employment Status: _____ Full Time _____ Part Time _____ Not Employed _____ Retired

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

REFERRED BY:

_____ Dr. _____ Phone Book

_____ Patient _____ Other _____

NAME OF GENERAL DENTIST: _____

NAME OF MEDICAL DOCTOR: _____ Phone _____

NAME OF MEDICAL SPECIALIST (i.e. Cardiologist): _____ Phone _____

EMERGENCY INFORMATION / PERSON NOT LIVING WITH YOU:

Name: _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

I understand that the responsibility for payment for services provided by this office for myself or my dependents is mine and is due and payable at the time services are rendered unless financial arrangements have been made. I agree to an 18% APR to be applied to the remaining balance after 3 months and until the account is paid in full. Accounts are not to exceed 6 months.

The policy of this office is the parent or guardian who accompanies a child and requests treatment for a child is responsible for the services rendered.

Signature of Patient or Responsible Party _____ Date _____