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_____

PHARMACY: (name & location) **_____** ***(phone)*** **_____**

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_____