Patient Information

Patient Name:		Preferred Name:	Date:	
Last ☐ Male ☐ Female	First	MI Married Single Child	Other	
Birth Date:	Steaming	cial Security#:		
	(Work);	(Pager/Cellular)		
Driver's License #				
Address Street		Δη	artment#	
		•		
City	200 to 1482	State Z	ip Code	
Employer Name		Occupation	*	
	Health I	nformation		
Current Medication	S		Self Self Self Self Self Self Self Self	
Date Of Last Denta	l Visit F	Reason for this visit	rance etrabuilt you	
Have you ever had	any of the followin	g? Please check those	e that apply:	
□AIDS/HIV	Excessive Bleeding		Stroke	
Allergies	Fainting	Mental Disorders	Tuberculosis	
	Glaucoma	Nervous Disorders	Tumors	
Anemia	Growths	Pacemaker	Ulcers	
Arthritis	Hay Fever	Currently Pregnant?	Venereal Disease	
Artificial Joints	Head Injuries	Due Date:	OTHER	
Asthma	Heart Disease	Radiation Treatment	-	
Blood Disease	Heart Murmur	Respiratory Problem		
Cancer	Hepatitis	Rheumatic Fever		
Diabetes	High Blood Pressure			
	pro			
Dizziness Epilepsy	Jaundice Kidney Disease	Sinus Problems Stomach Problems		
 Have you ever had any c If yes, please explain: Have you been admitted 		ntal treatment? Yes No	wo years? Yes 1	
If yes, please explain:		W Meann		
 Are you now under the ca If yes, please explain: 				
Name of Physician:		Phone:		
Do you have any health p Is yes, please explain:	problems that need further	clarification? Yes No	yes one of the fact period. Electrical to the fact periods of the fact of the	
	Referral	Information		
Whom may we thank for re				
		swers and information provided ne doctors at the next appoints		
	TO NAME OF STREET OF THE OWN OF	Date:		
Signature of patient, parent or gu	ardian	odo Aug	of Dimed , meters to some	
Dr. Signature	ologiczydzani	Date:		

Name:				
Relationship to patient Spouse P	Parent C	oild D Othe	p-	
Social Security #(Work):				
	EXI.	Best t	me to call:_	3805 (2) 1 (1) (2)
Address:		A northon	m+ 44	
Street		Apartme	nt#	
City		State	Zip Co	nde
Employer Name:			on	
Address:				
Street	City,	State Zip Co	de	Phone
Insurar	nce Infor	mation		Employer Name
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Primary Name of Policy Holder:			Is policy ho	Yes No
Last	First	MI	_a patientr	resno
Policy Holder's Birth Date:	ID	#	Groun	#
Policy Holder's Address:				
Street	A DIEWO	City	State	Zip Code
Policy Holder's Employer Name:				
Address:Street		City	State	Zip Code
Patient's relationship to Policy Holder: Insurance Plan Name and Address:_		Spouse		other
Secondary			Is policy ho	older
Name of Policy Holder:			The state of the s	Yes No
Last	First	MI		
Policy Holder's Birth Date:	ID#		_Group #_	
Policy Holder's Address: Street		City	State	Zip Code
Policy Holder's Employer Name:		estheriel.		the state of the s
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PAYMENT POLICY

We are pleased to offer our patients quality, state of the art dentistry. As a courtesy to the patient, we will bill the insurance for you. You are responsible for all charges incurred for your dental treatment. In order to maintain this type of service, we must insist upon the following payment guidelines:

PPO INSURANCE

We are a provider for many PPO plans. Members of these plans are required to pay their co-payment at the time services are rendered. Any unpaid balance is the responsibility of the patient.

PRIVATE INSURANCE

We work with all private insurance companies. We will estimate the patient's portion of fees according to the information given to us by your insurance company. This portion is due at the time services are rendered. Any unpaid balance, is the responsibility of the patient.

NO INSURANCE

Uninsured patients will be responsible for payments in full, at the time services are rendered.

FAILURE TO APPEAR

There is a \$25.00 charge for all failed appointments without a 24-hour notice.

CHECK CHARGE

There is a \$25 charge for all returned checks. We accept local checks with picture I.D., most credit cards, and cash.

We hope our policy is not an inconvenience to our patients. We do appreciate you choosing our office for your dental needs. Thanks again for your patronage.

AGREED X		
	Patient's Signature	