WELCOME

Your smile is important to us.

We want to welcome you to our office. Our dental team will make every effort to make your visit pleasant. Our goal is to provide quality dental care to you and your family.

PATIENT INFORMATION RECORD

Patient:_____ SS#:_____ Date of Birth:_____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Address: _____
City:_____ State:_____ Zip:_____
Phone #s Home:_____Work:_____Cell:_____
In the event of an emergency, whom should we contact?
Name:_____Relationship:_____Phone:_____

PATIENT/GUARDIAN SIGNATURE:_____

BILLING INFORMATION

MUST COMPLETE ALL SPACES

Person Responsible for Account:_____
SS#:_____DOB:_____
Address:_____
City:_____State:_____Zip:_____
Phone #s: Home:_____Work:_____Cell:_____
Email:_____
Relationship to patient:_____Employer:_____
Occupation:_____Employer's Phone:_____
Employer's Address:_____
City:_____State:_____Zip:_____

PLEASE READ: I understand and agree that I will be responsible for any balances for patients listed on this account. Broken appointments will be assessed a $25 fee and/or returned checks will be assessed a $25 fee of which I will also be responsible.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES STATED ABOVE. ***(MUST BE SIGNED BY PERSON RESPONSIBLE FOR THIS ACCOUNT)***

X_____ DATE:_____