PATIENT NAME ____
Last First Middle

ADDRESS ____

CITY ______________________ STATE ________ ZIP ____________

S.S. NO. ______________________ I.D. NO. ____________________

E-MAIL ______________________ CELL PH. (______) ____________

HOME PH. (______) ________________ WORK PH. (______) ____________

AGE __________ SEX (Circle One) M or F BIRTHDATE ____________

PATIENT EMPLOYED BY ______________________________________

ADDRESS ______________________________ ZIP ____________

PRESENT POSITION ______________________ HOW LONG ____________

NAME OF INSURANCE CO. ________________ GROUP NO. ____________

MARITAL STATUS (Circle One) Single Married

NAME OF SPOUSE ________________ BIRTHDATE ____________________

S.S. NO. ______________________ I.D. NO. ____________________

SPOUSE EMPLOYED BY ______________________________________

BUS. PH. ____________ ADDRESS ________________ ZIP ____________

PRESENT POSITION ______________________ HOW LONG ____________

NAME OF INSURANCE CO. ________________ GROUP NO. ____________

NAME OF NEAREST FRIEND OR RELATIVE (Not Living With You) ____________

ADDRESS ____

CITY ______________________ STATE ________ ZIP ____________

RELATION ______________________ PH. (______) ________________

REFERRED BY ____

METHOD OF PAYMENT (CIRCLE ONE) VISA MASTERCARD DISCOVER CHECK CASH

WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. YOU ARE, HOWEVER, RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT IN FULL, IF NOT PAID BY INSURANCE WITHIN 90 DAYS. YOUR CO-PAY AND DEDUCTIBLE ARE DUE AT THE TIME OF THE SERVICE. IF NOT INSURED, FULL PAYMENT IS DUE AT EACH VISIT.

PERMISSION FOR DENTAL TREATMENT

This is to verify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthesia as indicated.

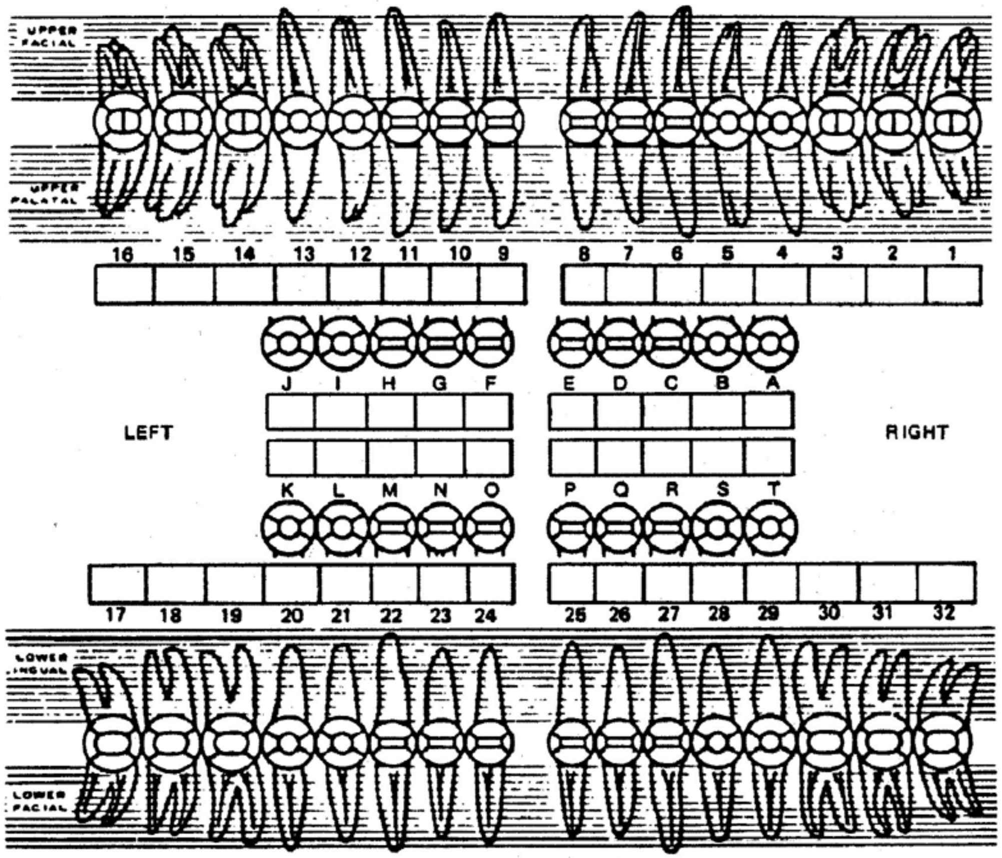
X Signature ______________________________ Date ____________

NOTICE TO PATIENT

$40.00 24/HR. CANELLATION FEE • $25 RETURNED CHECK CHARGES

DATE			SERVICES PERFORMED

NAME ______________________________ PATIENT # ____________
LAST FIRST MIDDLE



COMMENTS

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DATE			SERVICES PERFORMED

DATE			SERVICES PERFORMED