

Patient Information~PLEASE PRINT

Name _____	Birthdate _____ Age _____
Address _____	Male ___ Female ___
City _____ State _____ Zip _____	Marital Status:
Home # _____ Work # _____	Married ___ Single ___ Divorced ___ Widowed ___
Cell Phone # _____	
E-Mail _____	<u>Who should we contact in case of emergency?</u>
Employer _____	Name _____
Social Security Number _____	Relationship _____
	Address _____
<u>How did you hear of our office?</u>	Wk phone _____ Hm Phone _____
<input type="radio"/> Dental Referral: Dr _____	
<input type="radio"/> AT&T Yellow Pages—North County Costal	
<input type="radio"/> AT&T Yellow Pages—North County Inland	
<input type="radio"/> YellowBook—Costal	
<input type="radio"/> Senior Center—Brochure	
<input type="radio"/> Website or Insurance Co. (Circle one)	
<input type="radio"/> Friend or Neighbor _____	
<input type="radio"/> Internet _____	

Do you have dental insurance? Yes ___ No ___

We can make a copy of your card or fill this out:

Carrier Name _____

Subscriber _____

Policy # or SS# _____

Date of Birth _____

What are your dental problems, concerns or complaints?

What are your expectations for your appointment today?

In a perfect world, what would you like your smile, teeth or mouth to be like?

Agreement to Pay:

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If payment arrangements have been made and the payment is not paid within thirty (30) days of receipt of statement, interest at the then legal rate, plus a service charge may be added to the past due balance. If collection services are required I further agree to pay for all legal fees and costs incurred in connection therewith. Interest not paid when due shall be added to and become part of the principal and bears like interest until paid.

In the event a quotation of fees is not given by the doctor to me prior to the services being performed, I shall ask for such quotation or waive my right to later claim the fee exceeded the value of the service rendered.

If I am unable to keep any appointment, I agree to give 48 hours notice where feasible. **If appointment is broken without appropriate notice, this office reserves the right to charge \$75 for each hour of time reserved.**

I understand that I have the right to a copy of this agreement and waive same unless requested at the time of signing.

Signature _____ Date _____