PATIENT REGISTRATION:

Today's Date: _____

Patient's Name: _____ Birth date: _____

Social Security #: _____ - _____ - _____ Home Phone ( ) - _____

If a child, parent's name: _____ Spouse: _____

Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Patient's Employer: _____ Phone: ( ) - _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____

Person responsible for this account: _____

Purpose of this appointment: □Complete Care , □Emergency Only, Other: _____

Referred to us by: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that the information will be used by the Dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the office.

Patients are expected to pay for professional services as they are rendered unless special and specific arrangements are made in advance. A finance charge is computed on a periodic rate of 1 ½ % per month, which is an annual percentage rate of 18 % on any previous balance not paid within 30 days ($1.00 minimum).

Failed appointments are very costly for everyone. Therefore, a minimum charge of $50.00 will be automatically billed to your account for appointments not canceled at least 24 hours in advance.

Signature of patient (or parent if minor) _____