Patient Name ____
LAST NAME FIRST NAME MIDDLE INITIAL

Date of Birth ____/____/____ MALE / FEMALE SSN ______ - ______ - ______
Address ____________________ City ____________________ State ______ Zip __________
Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Minor ____
Employer ____________________ Address ____________________
Home Phone (______) ____________________ Work Phone (______) ____________________
Cell Phone (______) ____________________ E-mail: ____________________
Student Y / N School ____________________ City ____________________
Person Responsible for this account ____

Spouse/Parent's Name ____
Date of Birth ____/____/____ MALE / FEMALE SSN ______ - ______ - ______
Address ____________________ City ____________________ State ______ Zip __________
Home Phone (______) ____________________ Work Phone (______) ____________________
Employer ____________________ Address ____________________

Parent's Name ____
Date of Birth ____/____/____ MALE / FEMALE SSN ______ - ______ - ______
Address ____________________ City ____________________ State ______ Zip __________
Home Phone (______) ____________________ Work Phone (______) ____________________
Employer ____________________ Address ____________________

Whom may we thank for this referral ____

FEES AND PAYMENTS

All balances are **due in full at the time of service**, unless other arrangements are made prior to the start of treatment. All accounts 60 days old will have a 10% billing charge added to the balance. Any accounts that payment has not been received within 45 days will be considered for collection by an outside agency. I or we agree to pay all collection agency fees in addition to my unpaid balance, should the health care provider deem it necessary to employ an outside collection agency to assist in the recovery of my account. For your convenience our office offers the following methods of payment: **VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARECREDIT** (applications available upon request).

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist. I understand that I am responsible for all cost of dental treatment. I attest to the accuracy of the information on this page.

BROKEN APPOINTMENT POLICY

Broken appointments make it difficult for our office to maintain a schedule that is efficient for our staff and convenient for our other patients. If you find it necessary to cancel your appointment, we request you provide our office with 24 hours notice. Failure of this notification may result in a Broken Appointment Charge of $33.00.

Signature of Responsible Party ______________________________ Date ______________

REGISTRATION