Welcome . . . . . . *Thank you for selecting us.*

To help us meet your entire healthcare needs, please fill out this form completely, in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name____Date_______________

Soc. Sec. No. ________________________________ Birthdate __________________________________

Home Phone________________________________ Work Phone_______________________________

Address __________________________________City___________________State________Zip________

E-mail address____Do we have permission to email you?_________

FaceBook account____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If student, name of school or college ____________________________City_______________State_____

Patient's or Parent's Employer ____________________________________Work Phone________________

Business Address ____

City____State________Zip____________

Spouse or Parent's Name _______________________________Employer __________________________

Work Phone ____

Whom May We Thank For Referring You?____

Person to Contact in Case of Emergency ____________________________ relationship ____________________

Contact's phone number______________________________________

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Payment in full at each appointment.

Cash Personal check Credit Card: VISA MasterCard AMEX

NOVUS Dencharge

Dental Insurance

Employee Name__________________________________ Employee's DOB_________________________

Employer :____# of years _______________________________

Name of Insurance Company:____

Address:____

Telephone:____________________________________Program or Policy #: ___________________________

Union Local or Group:___________________________ Soc. Sec. No.:________________________________

RELEASE:

I authorize the dentist to perform diagnosis and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize use of my dental records (photos, xrays, and/or models) for educational purposes, such as seminars and lectures.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payer.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

____Date_________________

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I, ____have received a copy of this office's Notice of Privacy Practices.

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Signature Date