PATIENT INFORMATION SHEET

TITLE (Mr., Mrs., Ms., Dr.) First Name____________ Middle Initial________ Last Name ____________

I prefer to be called ____________ Sex: ❑ Male ❑ Female Drivers License No: ____________

Date of Birth____________ Age ________ Social Security No: ____________

Street ____________

City ____________ State________ Zip Code ____________ Email ____________

Home Telephone (____) ____________ Bus. Telephone (____) ____________ Spouse's Name ____________

Cellular No (____)____________ Referred By: ❑ Yellow Pages ❑ Red Book ❑ Dr. ____________

❑ Patient____________ ❑ Other____________

Responsible Party Information (If different than above) Social Security No.____________

Name ____________ Home Telephone (____) ____________ Date of Birth____________

Street ____________ City____________ State ________ Zip Code ____________

Employer ____________ Position ____________

Bus. Telephone (____) ____________ Cellular No (____)____________

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Homemaker

Marital Status: ❑ Married ❑ Divorced ❑ Legally Seperated ❑ Widow ❑ Single

Student: ❑ Full Time ❑ Part Time School Name/City/State ____________

In case of emergency: Name ____________

Phone____________

Relationship ____________

PATIENT EMPLOYER INFORMATION

Employer ____________ Phone (____) ____________

Street ____________ City____________ State________ Zip ____________

Position ____________

PRIMARY INSURANCE INFORMATION

Name of Insured:____________

Insured Date of Birth:____________

Insured Social Security:____________

Patient Relationship to Insured:____________

Insured Employer: ____________

Ins. Company: ____________

Ins. I.D. #: ____________

SECONDARY INSURANCE INFORMATION

Name of Insured: ____________

Insured Date of Birth: ____________

Insured Social Security: ____________

Patient Relationship to Insured: ____________

Insured Employer: ____________

Ins. Company: ____________

Ins. I.D. #:____________

Insurance Policy of Office

Our professional treatment is rendered to you, not to the insurance company. You, therefore, are directly responsible to us for payment for treatment. As a courtesy to you, we will fill out and submit claims to your insurance company. You will then be reimbursed by your insurance company according to the terms of your policy.

Billing Policy

Fees are openly discussed prior to treatment and we request payment for service to be made at time of treatment. If the balance on your account is not paid in full within 60 days from either you or your insurance company, you will be assessed a finance charge of 18% per annum computed monthly at 1.50% and not to exceed that amount allowed by law. If your account is placed in the hands of an agency for collection, you will be responsible for collection fees. If it becomes necessary to file suit against you to recover an outstanding balance, you will be responsible for collection fees, court costs and attorney fees.

I understand that the administration of local anesthetic may cause an untoward reaction or side effect, which may include, but not limited to, bruising, hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

Signature ____________(SEAL)_Date ____________