

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 In case of emergency: Name _____
Marital Status: Married Divorced Legally Separated Widow Single Phone _____
Student: Full Time Part Time School Name/City/State _____ 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 _____