PATIENT INFORMATION FORM

Name:
Home Phone: Work Phone:
Cell Phone: Email address:

Home Address: APT.#
City: Zip Code:
Social Security # Birthdate: Age:
Marital Status: Spouse's Name:
Nearest Relative not living with you:
Relationship: Phone:
Dentist: Phone:
Primary Physician: Phone:
Emergency Contact: Phone:
Responsible party: Phone:

Today's Payment: Cash Check Credit Card

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. Interest in the amount of 1.5% per month will be added to all outstanding balances after 90 days. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature Date

Parent (if minor) Date