PATIENT INFORMATION

PATIENT_____HOME PHONE_____
Last First Middle
EMAIL(OPTIONAL)_____CELL PHONE_____

ADDRESS_____BUS. PHONE_____

CITY_____STATE_____ZIP CODE_____

EMPLOYER_____SOCIAL SECURITY #_____

DATE OF BIRTH____/____/____SEX M___F___SINGLE___ MARRIED___ WIDOWED___ DIVORCED____

INSURANCE POLICY HOLDER_____DOB:_____/_____/_____

RELATION TO PATIENT: SELF____SPOUSE____PARENT____OTHER____

EMPLOYER_____

PRIMARY DENTAL PLAN_____COMPANY PHONE_____

PLAN ADDRESS_____

GROUP #_____MEMBER ID #_____

NAME OF EMERGENCY CONTACT_____ PHONE_____

IS ANY MEMBER OF YOUR IMMEDIATE FAMILY A PATIENT HERE?_____

WHO REFERRED YOU TO OUR OFFICE?_____

GENERAL DENTIST NAME_____

We understand that on occasion cancellations are necessary. Please remember, though, that each appointment time is reserved exclusively for that individual patient. Therefore, we require 48 hours notice or a fee of 50% of your scheduled charges will be assessed to your account. We would prefer to never make that charge. Thank you for making every effort to keep your appointments.

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable. I hereby authorize Matthew D. Ficca, DMD, MSD to furnish information to insurance carriers concerning services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.

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SIGNATURE OF PATIENT DATE