Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us we will be happy to help.

PERSONAL DENTAL OFFICE

PATIENT INFORMATION

P.T.L. _____________

Has any member of your family been a patient of our office? YES NO

Name: ____
(First) (Middle) (Last)

Address:____
(Street) (City) (State) (Zip)

Home Phone: ( ) _________-________ Work Phone ( ) _________-__________

D.O.B: _____/_____/_____ Age ______ Sex: Male Female S.S# ________-_____-_______

MARITAL STATUS

Minor Single Married Name of Spouse: __________________________________

Employer: ____
(Name of Company) (Address) (Phone)

Who should we contact in an emergency: __________________Phone: ________________

SUBSCRIBER/RESPONSIBLE PERSON

Name: ____
(First) (Middle) (Last)

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ( ) ________-_______ Work Phone ( ) _________-_________

SS#: _______-_____ -_________ D.O.B: _______/______/_______

Employer: ____Phone: ( ) _____ -______
(Name Of Company) (Address)

METHOD OF PAYMENT

Full payment for the dental treatment provided is expected at the time of service. For your convenience, we accept cash, checks, and all major credit cards. For our patients who need extended payments, we offer CARE CREDIT DENTAL FEE PLAN.

A note about keeping your appointments.

We reserve time for you. ***There is a charge for broken appointments.*** *Failure to notify the office less than 24 hours constitutes a broken appointment. (This applies only to weekdays)*

TRANSFER CANCELLATION PROCEDURE

PERSONAL DENTAL OFFICE reserves the right to not that a patient and ask that the patient transfer to another dentist of their choice when it is determined that the patient's conduct and/or requirements are detrimental to the best interest of the practice.