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_____ DATE OF BIRTH____/____/____

SEX M___F___ SINGLE___ MARRIED___ WIDOWED___ DIVORCED____

POLICY HOLDER ADDRESS (if different from patient) _____

RELATION TO PATIENT: SELF____SPOUSE____PARENT____OTHER____

EMPLOYER_____

PRIMARY DENTAL PLAN_____COMPANY PHONE_____

PLAN ADDRESS_____

GROUP #_____MEMBER ID #_____

NAME OF PREFERRED PHARMACY _____ PHONE _____

NAME OF EMERGENCY CONTACT_____ PHONE_____

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

WHO REFERRED YOU TO OUR OFFICE?_____

GENERAL DENTIST NAME_____

CANCELLATION POLICY

We understand that on occasion cancellations are necessary. Please remember that each appointment time is reserved exclusively for that individual patient. Therefore, we require 48 hours notice to reschedule or cancel an appointment. This enables us to offer that appointment to someone else who needs it. Thank you for making every effort to keep your appointments.

PERMISSION FOR TREATMENT

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.

PROMISE OF PAYMENT

I hereby authorize Matthew D. Ficca, DMD, MSD, PA 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. We ask that payment is rendered at the time of service. As part of our service to you, we file your insurance claim, in an attempt to speed up and maximize the benefit you are entitled, for re-imbursement directly to you.

SIGNATURE OF PATIENT DATE