# Patient Information (please print)

Status: __Child __Single __Married __Divorced __Widowed

Name ______________________________________________________________
Title First Middle Last

Birth Date_________________________ Social Security Number________-_____-________

Address__________________________________________________________________
Street City State Zip

Phone ( ) ____________( )_____________( )_______________________________
Daytime Evening Cell phone/pager Best time to call

E-mail ____________________________ California Driver's license # ______________________

Employer ____________________________________________________________
Company Name Address City State/Zip

Full Time Student? Yes No If Yes, What School __________________________________
Name/location Grade

If Minor, Responsible Party _____________________________________ relationship________
First Middle Last

Spouse's Name ___________________________________________________
First Middle Last

Birth Date_________________________ Social Security Number________-_____-________

Phone ( ) ____________ ( ) _____________ ( ) _______________________________
Daytime Evening Cell phone/pager Best time to call

Who can we thank for referring you? _________________________________________________

Have you seen us on TV _____ or on the Web ______? (Please check all that apply)

## Emergency Contact Information

Name _______________________________ Relation ______________ Phone ( ) __________

## Account Information:

Person responsible for account: ____________________________ Relationship_____________

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. I have read all of 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 understand it is my responsibility to inform this office of any changes to the information I have provided.
Our policy requires either payment in full or your estimated co-payment involving dental insurance for all services rendered at the time of visit, unless other arrangements have been made.
A missed appointment fee will be charged for all appointments missed or cancelled without 48 hour prior notice.
**There is a finance charge of 1.65% monthly (19.8% annually) that will be applied to all past due balances.**

_______________________________________________________________________________

Responsible Party's Signature Date