PATIENT INFORMATION

Patient Name _____
Last First Middle Initial Preferred Name

Address _____
Street City State Zip Code

Sex: M ☐ F ☐ Birthdate _____ **If patient is a minor, give parent or guardian's name** _____

Social Security # _____ Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ # years employed _____

Employer Address _____

Work Phone _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

(If different than patient's)

Name _____ Relationship to patient _____
Last First Middle Initial

Address _____
Street City State Zip Code

Sex: M ☐ F ☐ Birthdate _____ Social Security # _____ Home Phone _____

Employer _____ Occupation _____ # years employed _____

Employer Address _____

Is there insurance to bill? Yes ☐ No ☐

1. The above information is accurate and complete to the best of my knowledge.
2. I hereby authorize Dr. Freiboth to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. I understand that a 1% finance charge (12% per annum) will be assessed on all accounts outstanding 90 days or more, in addition to any collection charges needed to collect on this account.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Signature _____ Date _____