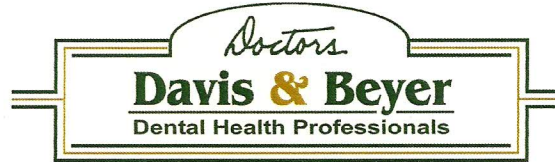


1218 E. Venice Ave.
Venice, FL 34285
(941) 488-1075
Fax: (941) 484-6277



www.venicedentist.com
Email: info@venicedentist.com

"Excellence by Choice"

PATIENT INFORMATION

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Out of town Address: _____ City: _____ State: _____ ZIP: _____

Email Address: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Place of Birth: _____

Sex: M F Marital Status: Married Single Widowed Divorced Student

Place of Employment: _____ Occupation: _____

Spouse or Parent's Name: _____ Employer: _____ Phone: _____

Has any member of your family ever been treated in our office? Yes No

Whom may we thank for referring you? _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: _____ Tel #: _____
Address: _____ City: _____ St _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____
Insurance Co: _____
ID/SNN Number: _____
Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name: _____
Insurance Co: _____
ID/SNN Number: _____
Group #: _____

METHOD OF PAYMENT: I prefer to pay by: Check Cash Credit Card

FINANCE CHARGE: If I do not pay the entire New Balance within 25 days of the statement date a FINANCE CHARGE will be added to the account for the billing period. The FINANCE CHARGE will be periodic rate of 1% per month which is an ANNUAL PERCENTAGE RATE OF 12%. In case of default of payment I promise to pay any legal interest on the balance due, together with Any collection costs and reasonable attorney fees incurred to effect collection of this account.

APPOINTMENTS: Please be advised 24 hours notice must be given if a cancellation is absolutely necessary, otherwise you will be charged a cancellation fee.

AUTHORIZATION: I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer medications, perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the above information & medical history is true and correct to the best of my knowledge.

Patient Signature: _____

Please Continue Filling Out Your Information On The Other Side Of This Form

