

ACCOUNT# _____

DATE _____

PATIENT INFORMATION

Name _____

I prefer to be called: _____

Male Female Marital Status: S M D W

DOB ____/____/____ SS# ____-____-____

Home Address _____

City _____ State _____ Zip _____

Please check preferred method of contact below:

Home Phone _____

Work Phone _____

Cell Phone _____

E-Mail _____

Patients Employer _____

Occupation _____

How did you hear about our office? If referred, whom may we thank? _____

Please list other family members seen by us

EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone _____

Work Phone _____

SPOUSE/PARTNER INFORMATION

Name _____

Employer _____

Occupation _____

Work Phone _____

DOB ____/____/____ SS# ____-____-____

Smiles@Southcenter

DOREEN M. ROSETO, DDS ❖ THUY L. NGUYEN, DDS

BILLING INFORMATION

(Complete this only if billing information is different from patient information section)

Person Responsible For Account or Insured

Relationship to patient _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Employer _____

DOB ____/____/____ SS# ____-____-____

Permission for treatment- I hereby grant permission to the health care providers of Smiles@Southcenter Dentistry to employ such established treatments and therapy as may be deemed professionally necessary or advisable.

The information I have given today is true to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status.

Financial Agreement- All charges for services and treatment will be paid upon completion of appointment. Outstanding balances shall accrue interest monthly.

If insurance is involved- I hereby authorize payment directly to Drs. Roseto and Nguyen of Group Insurance Benefits otherwise payable to me.

Broken appointments- I understand that appointments changed without 24 hours notice may be assessed a broken appointment charge.

Signature: _____

Date: _____