HEALTH HISTORY & REGISTRATION

Patient _____ Nick Name _____ Date _____
Last First Middle

Home Phone _____ Patient's Birthdate _____ Soc. Sec. # _____

Cell Phone _____ Email _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Patient is minor:
Responsible party _____ Soc. Sec. # _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Bus. Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse _____ Soc. Sec. # _____
Last First Middle

Spouse's Employer _____ Occupation _____ Bus. Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Referred by _____

Nearest Relative Not Living in Your Household _____

In Case of Emergency _____ Relationship: _____

Phone ( ) _____ Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION:

Insured's Name _____

Insured's Birthdate _____

Insurance Co. _____

Ins. Co. Address _____

_____

Policy # _____ Plan/ID# _____

SECONDARY INSURANCE (If applicable)

Insured's Name _____

Insured's Birthdate _____

Insurance Co. _____

Ins. Co. Address _____

_____

Policy # _____ Plan/ID# _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient, and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, "upon receipt of full (or partial) payment of bill." We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

TERMS OF PAYMENT: Payment is due upon treatment, unless other financial arrangements have been made.

IN THE EVENT OF NON-PAYMENT: Interest will accrue at the highest lawful rate from the date of treatment. Collection costs (including attorney's fees in the amount of twenty-five percent of the unpaid fee) will be borne by patient. Patient agrees that Maryland law will apply with relation to this contract.

SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

OFFICE NOTES

DATE	