PATIENT INFORMATION

DATE______________________________

NAME____ PHONE (H)____________________________________
Last First Middle

E-MAIL: ____ CELL#_______________________________________

Best option to confirm appointments: E-MAIL ________ and/or TEXT _______ (Please check)

Address___________________________________ City_________________________ State__________ Zip______________
Number and Street

Date of Birth_________________ Sex_______ S.S.#_______________________________ Marital Status S__M__D__W__

Place of Employment / College______________________________________ Business Phone______________________________

Closest Relative_____________________________ Phone________________ Referred by________________________________

Person responsible for Bill____

IF FILLING OUT FOR A CHILD

Mother's Name_________________________________Address________________________________Phone_______________

Place Employed_________________________________ Business Phone______________________ S.S.#___________________

Father's Name___________________________________Address_______________________________Phone________________

Place Employed_________________________________ Business Phone______________________ S.S.#___________________

MINOR/CHILD CONSENT

PATIENT NAME____

My permission is given to John Gomes Jr., DMD, Gregory M. Bartek, DMD, and staff to provide treatment as deemed necessary including X-rays, Fluoride, and any Emergency Care.

Signature _________________________________ RELATIONSHIP TO PATIENT ___________________________________

ASSIGNMENT AND RELEASE - Lifetime Authorization and Release of Information

I request that payment of my insurance benefits be made directly to East Grove Family Dental, Inc. on my behalf. I authorize the release of information needed to determine dental benefits. This one time authorization will remain in effect unless cancelled in writing. I further understand that I am responsible for all deductibles, copayments, denials and noncovered services.

Date_______________________________ Signature ____
PATIENT/GUARDIAN IF MINOR CHILD

FINANCIAL AGREEMENT

I understand that payment is due at the time of treatment, unless other arrangements have been made. **In the case of minor children, the parent or guardian that presents the minor for treatment is responsible for payment. We cannot bill a third party** (only 1 bill per family will be issued.) Nonpayment of account will result in collection charges if your account is referred for collection purposes.

Date __________________________________ Signature____
PATIENT/GUARDIAN IF MINOR CHILD