Dousman FAMILY DENTISTRY

PATIENT INFORMATION

PATIENT Last Name: _____ First Name: _____ MI: _____

Please Select ☐ Male ☐Female Title: Please Select ☐ Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other _____

Home Address: _____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Employer's Name: _____ Date of Birth: _____

Business Address: _____ Social Security#: _____

Name & Number & Relationship of Nearest Living Relative Driver's License#: _____

_____ Home Phone#: _____

_____ Business Phone#: _____

Whom May We Thank For Referring You To The Office? Cell Phone#: _____

_____ Email Address: _____

Spouse Information (if applicable)

Last Name: _____ First Name: _____ MI: _____

Social Security#: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Employer's Name & Address: _____

Business Phone: _____

Responsible Party Information Last Name: _____ First Name: _____ MI: ____

Relationship to Patient: ☐Self ☐Parent ☐Guardian ☐Spouse ☐Other: _____ Date of Birth: _____

Address (If Different From Patient): _____
(Street Address) (Apt/Suite#) (City) (State) (Zip Code)

Social Security#: _____ Home Phone#: _____

Driver's License#:_____ Business Phone#: _____

Employer's Name: _____ Cell Phone#: _____

Email Address: _____

Account Responsibility: The Undersigned agrees to pay a $25 fee for any returned checks. The undersigned is aware that a charge may be made for broken appointments and that interest of 1% per month will be charged on all accounts which are over 90 days past due. If it should become necessary to place this account in the hands of an Attorney for collection, the undersigned agrees to pay and amount equal to one-third of the unpaid principal as an Attorney fee, plus all court costs. I understand and agree that the terms herein are reaffirmed each time services are received.

X _____ Date: _____
Responsible Party Signature

HIPAA (Health Insurance Portability and Accountability Act) Acknowledgement of Receipt of Notice of Privacy Practices. By signing below, the Patient/Responsible Party certifies that they have received a copy of the notice of privacy practices for this office.

X _____ Date: _____
Responsible Party Signature