JAMES D. SPALENKA, D.D.S.

(PLEASE PRINT)

PATIENT INFORMATION

LIKES TO BE CALLED _____ LAST NAME PRONOUNCED _____

NAME: MR. MRS. MS. DR. _____ BIRTHDATE _____
FIRST MIDDLE LAST

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____

EMPLOYER OR SCHOOL _____ SSN. _____

IF PATIENT IS A MINOR, PLEASE GIVE PARENTS OR LEGAL GUARDIANS' NAME: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

CHILDREN:

NAME _____ DATE OF BIRTH _____ NAME _____ DATE OF BIRTH _____

NAME _____ DATE OF BIRTH _____ NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY INFORMATION

NAME _____
FIRST MIDDLE LAST MARITAL STATUS RELATIONSHIP TO PATIENT

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY NO. _____ BIRTHDATE _____ DRIVER'S LICENSE NO. _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____
FIRST MIDDLE LAST

SPOUSE'S EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

INSURANCE INFORMATION

INSURED'S NAME _____ BIRTHDATE _____ SSN. _____

INSURANCE COMPANY & ADDRESS _____

_____

INSURED'S EMPLOYER _____ GROUP NO. _____ LOCAL NO. _____

DO YOU HAVE DUAL (SECONDARY) COVERAGE? YES NO; If yes, please complete the following:

INSURED'S NAME _____ BIRTHDATE _____ SSN. _____

INSURANCE COMPANY & ADDRESS _____

_____

INSURED'S EMPLOYER _____ GROUP NO. _____ LOCAL NO. _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment, or any dental treatment performed without prior financial arrangements will be paid for at the time treatment is performed. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all dental treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 90 days. I grant my permission to your office to telephone me at my home or my work to discuss matters related to this form or my dental treatment. I realize that appointment times are reserved and that if I fail to give at least 24 hours notice, I may be charged a fee. If my account should be sent to a collection agency, I will be rsponsible for all fees, charges, court costs, and attorney fees added to my account. I also understand that the financial responsibility belongs to me even if I am covered by insurance. Should my insurance be billed by this office, I authorize the Dentist(s) and/or their staff to furnish information to the insurance carrier necessary to complete and/or settle my dental claim. To the best of my knowledge, the above statements on this form are true and complete.

PLEASE INQUIRE ABOUT ANY QUESTIONS WHICH ARE NOT UNDERSTOOD

CONSENT OF TREATMENT

I do authorize and give consent to administer treatment, including, but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I further state that the medical and dental history was completed fully and accurately to the best of my knowledge.

_____
PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE TODAY'S DATE