PATIENT ACQUAINTANCE FORM

Name _____ Birthdate ___ / ___ / ___

Address _____ City _____ State ____ Zip _____

Res. Phone _____ Cell _____ May we contact you at work ❒ yes ❒ no

Place of Employment _____ Employer Phone _____

Name of Spouse _____ Birthdate ___ / ___ / ___

Place of Employment _____ Employer Phone _____

DEPENDENTS	BIRTHDATE	DEPENDENTS	BIRTHDATE
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___
_____	___ / ___ / ___	_____	___ / ___ / ___

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT THAN ABOVE:

Name _____ Relationship _____ Phone _____

Address _____ City _____ State ____ Zip _____

I give the office of Peterson Dental Associates PA, permission to release my information to the person listed as responsible for account. ☐ Yes ☐ No

Whom may we thank for referring you to our practice? _____

Name and address of previous dentist? _____

In case of an emergency, who should we notify?

Name _____ Relationship _____ Cell _____

Address _____ City _____ State ____ Zip _____

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.

A monthly late charge of .66% per month (8% APR) will be charged to all account balances over 60 days past due. The late charge will remain in effect until the balance has been paid in full.

IF PATIENT IS A MINOR PLEASE COMPLETE

I give my permission to Dr. Thomas Peterson or Dr. Russell Peterson, and/or their designated assistant(s) to perform any and all dental techniques and procedures, including but not limited to the administration of nitrous oxide sedation and anesthetics on my minor child(ren) _____, whether or not I am present at the actual appointment when the treatment is rendered. I further agree to be financially responsible for all treatment rendered to the above named child(ren).

Signed _____ Date _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM IF COVERED BY INSURANCE