Print Form

Towne Pointe Dental

Patient Information

☐ M ☐ F

Patient Name (Last, first, MI) | Date of Birth | Sex

Occupation | Social Security #

Home Phone | Cell Phone | Work Phone | ☐ Married ☐ Single ☐ Other Status

Email | Mailing address (Street)

How would you like to receive appointment reminder or communication ?
☐ Text message ☐ Email ☐ Call

City, ST ZIP Code

Guardian/Alternative Emergency Contacts

Name (First, Last) | Relationship

Home Phone | Cell Phone | Address (If different from the patient's)

City, ST ZIP Code

Referral Information

How did you find out about us ? ☐ Print Advertisement::_____ ☐ Our Website ☐ Work ☐ Friend

☐ Another office: _____ ☐ Family/Relative ☐Other_____

Whom may we thank for referring you to our practice :

Name

Please initial at the line after acknowledge each statement:

_____ I certify the above information is correct to the best of my knowledge.

_____ I understand that I am financially responsible for this **patient's account. I understand and accept that payment is due at the time of service unless we accept insurance assignment** for a covered service.

_____ I understand that 2 business days (48 hours) notice is required for changing an appointment.

_____ I also acknowledge that a cancellation fee of $30 will be charged if this office is not notified 48 hours prior to the cancellation of an appointment, except in the case of an emergency.

Signature of Responsible Party:_____Date:_____