<u>M</u>	EDICAL ALER	<u>[S</u>					<u>ALL</u>	<u>.ERGI</u>	<u>ES</u>			
Today's Date:	/ /											
PATIENT INFORMATION												
Last Name:		First:	TIAI	<u> </u>		Middle:	.	Mari	tal status (circle on	a)	
Address:		riist:				Middle:	•	Single / Ma	•		=)	
City:		State:		Zip:			Birth d		Age:	Sex:		
SSN:		Employer:	·			/ /			Age.	□ M	□ F	
Home Phone: ()						Work Phone: ()					
Dental/Medical Insurance Company:					E-Mail:							
,	rred: ☐ Self ☐ Spouse ☐ Chil		E riuli.									
GUARANTOR / PRIMARY INSURANCE INFORMATION												
Last Name:		First:				Middle	e:	Mar	ital status (circle on	e)	
Address:								Single / N	Mar / Div ,	/ Wid		
City:		State:		Zip			Birth o	date:	Age:	Sex:		
SSN:		Employer:					/	/		□ M	□F	
Home Phone: ()	Cell Phone: ()			W	ork Pho	ne: ()			
Dental/Medical Insurance Co: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other												
	SECON	DARY INSU	JR/	NC	E INFOI							
Last Name:	First:					Middle	Middle: Marital status (circle one)					
Address:				1			l		Mar / Div ,			
City:		State:					Birth date:		Age:	_		
SSN:	``	Employer:	1 ,				/ /					
Home Phone: () Cell Phone: ()						Work Phone: () lationship to Insured: □ Self □ Spouse □ Child □ Other						
Dental/Medical Insurance Co:												
How did you hear about our office?												
IN CASE OF EMERGENCY												
Name: Relationship to pat												
Home Phone: ()	Cell Phone: ())			rk Phor	ne: ()			
and agreed to as ne for education or scie consultation. I authorallowed by my plantreatment, regardles billed. I acknowledg will pay for any colle upon time. I acknow whichever is greater on a 1 hour appoint	curpose of examination, x-ray, ecessary for the purpose of dience. I authorize the release or orize payment directly to the correct (Some PPO's will not pay direct is my responsibility to pay ections or legal charges incurved the correct or missed appointment and a 48 hour notice for use at the time of scheduling to	agnosis, identification of my records to a do above name dentist of ectly regardless of automated it is liked that portion not covered in the collection of a loss if I do not keepents. I acknowledge to any appointments of	n, predoctor or of the outhorizably and vered both the or one or one of the of	eterming r doctor group ir ation) I probab y insura vered c ppointm 24-hour	ation of insurars of my choosinsurance beneficially understand the let that my insurance (estimate tharges should thents, and I cannotice is required.	ance or ing as rifts other at I amurance ed co-part I fail to no be chired for	demons may be erwise p respon benefits ay) at the pay the parged a	stration deemed for payable to m asible for all s will be less ne time char em during t a fee of \$50 ncellation	ne if costs of desthan the arges are incodes:	ental imount		
Patient's signatur	Date	Witness signature					Date					