At Dental Health we strive to help you personally understand what is necessary to have a healthy smile and good chewing forever. Thank you for helping us serve you by providing the following confidential information.

Circle one: Mr. Dr. Mrs. Ms.	Today's date	Today's date			
Patient name			Marital Statu	ıs:	
Spouse			Single	Widowed	
Address			Married	Widowed Divorced	_
AddressCity	St	Zip_	Civil Union		_
Date of Birth	Sex: Male	Female SS#			
Home phone	work phor	ne	cell	phone	
Home phone What do you like to be called?		e-ma	il		
If patient is under age 18:					
Name of accompanying parent			Phone		
A 11 :C 1:CC C1					
So that we may better inform yo	ou of your child	's necessary tre	atment, we ask th	at a parent accomp	any the child
to all appointments.	<i>y</i>	,	,	rr	,
budget is a concern our financia may have your necessary care is payment plans be arranged prio	n a timely way v	ve have several			
Interest is applied to all outstand	ding balances at	1.5% monthly	(18% annually)	Patients are legally	z responsible
for all charges associated with t	•	-		0 1	responsible
Tot wit onwigos associated with		•14.4.11.8	.011 4114 10841 1000.		
For those who have dental ins maximum benefit allowed.	urance, we wor	k with all plans	s and will do our b	est to help you rec	eive the
			Date of R	irth	
Name of insured employee Subscriber ID#			Group #		
Fmployer	SS#				
Employer Insurance company name		Incurat	nce nhone		
Insurance company claim addre			<u> </u>		
msurance company ciann addre	33				
By signing this document I veri	fy that all inforr	nation provided	l is correct and cu	rrent. Also, I give j	permission
for Dental Health to send neces must see by referral.	sary x-rays and	information to	my insurance com	npany and or any sp	pecialist I
Signature		Date			

Thank you for your time and for coming to Dental Health. Dr. David Neumeister and Dr. Tom Heydinger