Welcome To Our Office

Please complete this form to the best of your ability. If you have any questions we will be happy to assist you.

Full Legal Name: ____ **Date of Birth:**____________________

First *MI* *Last*

Male □ Female □ Minor – under 18 years □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □

Preferred Name/Nickname:__________________ ___ **Social Security #** ____________________________________

(required for all patients 18yrs+ and/or the responsible party)

Home Phone_____________ **Work#**_____________ **Cell#**_______________ **Email** ___________________________

As a courtesy, we confirm appointments. Do you prefer a call at: HOME WORK CELL or EMAIL

Address:____

House/Apt# *Street* *City* *State/Zip*

Patient Employer____________________________________ **Occupation**__________________________________

Family Information (required for Minors)

Mother/Father/Guardian _____________________________________ Day# _____________________________________

Emergency Contact/Relationship_____________________________________ Day#______________________________

Do you have dental insurance? YES NO

Dental Insurance Co.___________________________ Group#______________ ID#_____________________

Subscriber Name_______________________________________ Employer_____________________________

Social Security#_________________________________ Date of Birth_________________________________

Subscriber's Address ____

Additional (Secondary) Insurance

Dental Insurance Co.____________________________ Group#_____________ ID#_____________________

Subscriber Name_______________________________________ Employer_____________________________

Social Security#________________________________ Date of Birth___________________________________

Subscriber's Address ____

Authorization for Treatment at the office of Frederick R. Levine, D.D.S.

I understand that I am responsible for all costs of dental treatment, regardless of any insurance, and/or financial situations. Co-payments are due at each appointment. I also accept that it is my responsibility to obtain and understand all details of my insurance plan(s). In the event that I do not honor payment for services rendered, my account may be turned over to a collection agency. Also, I and my family may be terminated as patients.

I hereby authorize this Dental Office to administer medication, perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that no one can predict the response of living tissue to dental or medical treatment, and it is always possible for complications to arise. **There can never be any guarantee as to actual results of treatment - or my satisfaction**. **I recognize that fees paid are for the time spent by the doctor and staff in their efforts to help me with my dental condition.** **Fees paid are not for actual items, nor results.** My decision to have treatment will be based upon a review of my condition with the doctor and/or staff, including discussion of currently accepted options and the risks of no treatment. ***I also understand there is a $75.00 fee for broken appointments.***

Signature of Responsible Party:____ Date_________________

[ ] Mother of Minor [ ] Father of Minor [ ] Legal Guardian [ ] Other__________________________

Whom should we thank for referring you to our office?_____________________________.