

Acquaintance Form

Today's date: _____

PATIENT INFORMATION

Patient's Name _____ Male _____ Female
LAST FIRST MI NICKNAME

Address _____
STREET CITY ST ZIP BIRTHDATE

Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Driver's License # _____ SS# _____

Employer _____ Occupation _____

Spouse's Name _____ Marital Status _____

Spouse's Employer _____ Occupation _____

Spouse's Work Phone _____ Other Insurance? _____

Who can we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Name _____ Relation to Patient _____
LAST FIRST MI

Address _____ Birthdate _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

Drivers License # _____ Social Security # _____

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, who should be notified?

NAME _____ CELL PHONE _____ OTHER PHONE _____

PHYSICIAN _____ PHONE _____

OTHER INFORMATION

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. I WILL INFORM YOUR OFFICE OF ANY CHANGES, INCLUDING BUT NOT LIMITED TO MEDICAL HISTORY, INSURANCE AND CONTACT INFORMATION AT THE NEXT APPOINTMENT. I UNDERSTAND THAT TREATMENT MAY CHANGE ONCE A PROCEDURE IS STARTED AND ADDITIONAL CHARGES MAY INCUR AS A RESULT OF ACTUAL WORK DONE. IF ADDITIONAL TREATMENT IS NEEDED DURING MY PROCEDURE AND IF MORE CHARGES WILL BE INCURRED AS A RESULT, I WILL BE RESPONSIBLE FOR THE ADDITIONAL CHARGES. I FURTHER UNDERSTAND THAT CO-PAYMENT AMOUNTS QUOTED ARE ONLY ESTIMATES AND ARE NOT A GUARANTEE OF BENEFITS BY MY INSURANCE COMPANY. I WILL BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES. IF MY INSURANCE COMPANY DENIES PAYMENT OR CHANGES ITS COVERAGE FOR ANY REASON, THE BALANCE WILL BE MY RESPONSIBILITY.

Signature of Patient or Guardian

Date