

WELCOME TO TAMARAC DENTAL CARE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs. Information is strictly confidential and will not be released to anyone without your written permission.

PATIENT INFORMATION

Date _____ Age _____ Social Security # _____ - _____ - _____ Birthdate _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Mobile Phone _____
E-Mail Address _____ FAX _____
Employer _____ Occupation _____
Business Address _____
City _____ State _____ Zip _____
Whom may we thank for referring you? _____

EMERGENCY CONTACT

Name _____ Phone _____
Address _____
City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Phone _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Address _____
City _____ State _____ Zip _____
Employer _____ Occupation _____
Address _____
City _____ State _____ Zip _____

I understand that I am financially responsible for all charges, whether or not paid by my insurance, for all services rendered on my behalf or my dependents. I authorize the doctor and/or provider of services to release any information required to secure payment of benefits. I authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents. I understand a service charge for missed appointments will occur if 48 hour prior notification of cancellation does not occur.

Signature _____ Date _____
State Drivers License# _____