PARADISE DENTAL
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Welcome to Paradise Dental. We are committed to excellence in dental care and are proud of our dedication to our patients.

Section 1: PATIENT INFORMATION:

Today's Date:

Patient Name:	**Birth Date:**	**Age:**	**Gender: M F**
Social Security Number:	**Driver's License Info:** **Number:** **State:**		**Occupation:**
Marital Status Info: **Single: [ ] Married: [ ] Divorced: [ ] Separated: [ ] Widowed: [ ]**	**Employer Name:**		

Section 2: EMAIL, TELEPHONE AND ADDRESS INFORMATION

Email Address:	**Home # Work # Mobile #**
Address: **State:** **Zip:**	**City:**

Section 3: EMERGENCY CONTACT INFORMATION

Person Name:	**Relationship:**	**Work #:** **Mobile #:**

Section 5: MAIN SUBSCRIBER OR PERSON RESPONSIBLE FOR INSURANCE/ ACCOUNT (IF DIFFERENT FROM PATIENT)

Full Name:	**Birth Date:**	**Social Security Number:**
Relationship:	**Work #:** **Mobile #:**	**Employer:**

Whom may we thank for referring you:

Friend/Relative Name: **Insurance Company:** **Web Site:**

Direct Mail: [ ] Walking By: [ ] Yahoo: [ ] Bing: [ ] Facebook: [ ] Other Internet: [ ] Magazine Name:

Section 8: NOTICES(PLEASE INITIAL BELOW ON EACH ROW)

[_____]I have read and understood the Dental Materials Fact Sheet.

[_____]I have read and understood HIPPA (Notice Of Privacy Act).

[_____]I will answer all health questions to the best of my knowledge

[_____]**$65.00** Charge for missed appointments not cancelled 24 hours before the appointment time

Section 10: AGREEMENT TO PAY

I agree to pay for all services rendered at the time of the service. In the event that payment is not made with thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to arid become part of principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Signature:	**Date:**