WELCOME!

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions , please do not hesitate to ask.

Date_____

Patient Information

Name_____
Last First Middle Initial

Address_____Phone_____

City_____ State_____ Zip Code_____

Sex □F □M Age_____ Birth date_____ Soc. Sec._____-_____-_____

Please check if you would like to receive E-mail correspondence □ E-mail address_____

Patient Employed by_____ Bus. Phone_____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

Primary Insurance Information

Person Responsible For Account_____
Last First Middle Initial

Relation to Patient_____ Birth date_____ Soc. Sec._____-_____-_____

Address (if different from patients)_____ Phone_____

City_____ State_____ Zip Code_____

Person Responsible Employed by_____ Business Phone_____

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

Secondary Insurance Information

Is patient covered by additional insurance?_____

Person Responsible For Account_____
Last First Middle Initial

Relation to Patient_____ Birth date_____ Soc. Sec._____-_____-_____

Person Responsible Employed by_____ Phone_____

Insurance Company_____

Contact #_____ Group #_____ Subscriber #_____

Patient acknowledgments:

- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by Dr. Nicole Leiker in scientific papers or demonstrations, and patient education.
- I consent to the publication of my photos released to Dr. Leiker by other healthcare providers.
- I understand that all charges incurred, and not covered by dental insurance, are payable at the time of service.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

Signature_____ Date_____