PATIENT INFORMATION

Has any member of your family been a patient of our office? ☐YES ☐NO

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____)_____-_____ Work: (_____)_____-_____ Cell Phone: (_____)____-_____

D.O.B: ____/_____/_____ Age_____ Sex: ☐Male ☐Female SSS#_____-_____-_____

E-Mail Address: _____

Employer: _____
(Name of Company) (Address) (Phone)

MARITAL STATUS

☐Minor ☐Single ☐Married Name of Spouse: _____

Who should we contact in an emergency: _____ Phone: _____

SUBSCRIBER/RESPONSIBLE PERSON

Name: _____
(First) (Middle) (Last)

Address:_____
(Street) (City) (State) (Zip)

Home Phone: (____)_____-_____ Work Phone: (____)_____-_____

SS#:_____-_____-_____ D.O.B:_____/_____/_____

Employer: _____ Phone: (____)_____-_____
(Name of Company) (Address)

Whom should we thank for referring you to our office: _____

METHOD OF PAYMENT

Full payment for the dental treatment provided is expected at the time of service. For your convenience, we accept cash, checks, and all major credit cards. For our patients who need extended payments, we offer ***CARE CREDIT/WELLS FARGO HEALTH ADVANTAGE CREDIT CARD PROGRAM***

APPOINTMENT CANCELLATION

Patient agrees that it is the patient's responsibility to notify K&E Family Dental 48 hours in advance to cancel a scheduled appointment. K&E Family Dental reserves the right to bill patient for cancellation fee of $50.00 for missed appointment and/or failure to notify K&E Family Dental in advance.

TREATMENT PROCEDURE CANCELLATION

K&E FAMILY DENTAL reserves the right to not treat a patient and ask that the patient transfer to another dentist of their choice when it is determined that the patient's conduct and/or requirements are detrimental to the best interest of the practice.