APEX DENTAL

Patient Information

Patient name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Soc Sec #:_____

Responsible Party (if not same as patient)

Name:_____

Address :_____(if not same as patient)

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Soc Sec:_____

Dental Insurance Information

Policy Holder:_____ DOB _____ID#_____

Insurance Company:_____ Telephone #_____

Employer:_____ Group #_____

Referral Information

We would like to know how you found out about our office: Please indicate what brought you today
Patient_____ Another Office _____
Neighborhood Magazine ( ) Insurance Co. ( ) Walkby ( ) Internet Search _____
1-800 Dentist ( ) Zoc Doc ( ) Other _____

******PLEASE ASK ABOUT OUR VERY GENEROUS PATIENT REFERRAL PROGRAM******

Financial Agreement

I understand that all insurance payments are an estimate and are not a guarantee of payment. Pre-treatment estimations are done by request only. I understand I am ultimately responsible for ALL fees incurred for services at the start. **I understand that I will be charged $50 for failed appointments or cancelled appointments without a 48 hour notice.**

Signature (Patient/responsible party)_____Date _____