MONTICELLO FAMILY DENTAL

This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please free free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here!

PLEASE PRINT

Mr / Mrs / Miss: _____ Birthdate: _____
First Middle Initial Last Month / Day / Year

Home Phone Number: _____ Soc. Sec. #: _____

Home Address: _____ City & Zip: _____

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Address: _____

Work Phone: _____ Present Position: _____

Spouse's Name: _____ Soc. Sec. #: _____

Employer: _____ Birthdate: _____

Work Phone: _____ Work Address: _____

Dental Insurance Co: _____ Insured's Employer: _____

Insurance Co. Address: _____ Phone #: _____

Group or Plan #: _____ Subscriber ID #: _____

BILLING

Person Responsible for Bill: _____ Birthdate: _____

Relationship to you: _____ Soc. Sec. #: _____

Billing Address: _____ City & Zip: _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____ Whom may we thank for referring you to us? _____

APPOINTMENTS: We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment. Not showing or canceling same day may result in a fee and possible loss of future appointment privileges.

INSURANCE: To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

_____ _____
Signature Date