PATIENT INFORMATION

DATE: ______________________________

FULL NAME: (Last, First, Middle) ______________________________

LOCAL STREET ADDRESS ______________________________

CITY:______________________________ STATE:____________________ZIP:____________________

NORTHERN ADDRESS (Street, City, State, Zip): ______________________________

HOME PHONE:______________________________ BUSINESS PHONE: ______________________________

EMPLOYER: ______________________________ ADDRESS: ______________________________

OCCUPATION: ______________________________ ______________________________

DATE OF BIRTH: ____________________ SEX: ❑ Female ❑ Male HEIGHT: ______________ WEIGHT: ______________

MARITAL STATUS: ❑ Single ❑ Married ❑ Divorced ❑ Widow(er)

PATIENT DRIVER'S LIC #: ______________________________ PATIENT SOCIAL SECURITY #: ______________________________

SPOUSE'S OR PARENT'S NAME & OCCUPATION: ______________________________

PERSON RESPONSIBLE FOR ACCOUNT: ______________________________

DRIVER'S LICENSE #:______________________________ SOCIAL SECURITY #: ______________________________

ADDRESS (Street, City, State, Zip): ______________________________

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE PREVIOUSLY? ❑ Yes ❑ No

IF YES, WHO? ______________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________________

DENTAL INSURANCE: ❑ Yes ❑ No

WHY DID YOU CHOOSE DR. WILLEY AS YOUR DENTIST? ______________________________

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ______________________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates.
   I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Signature: ______________________________Date:______________________________

PERSONAL HISTORY