POWDER RIVER DENTAL

PATIENT INFORMATION

Please complete the following confidential information

Date _____

Patient Name _____

Spouse or Parent _____

Street Address _____

Mailing Address _____

City _____ ST _____ Zip _____

Home Phone # _____

Cell Phone # _____

Text-message reminders? Yes ☐ No ☐

Work Phone # _____ Ext. _____

Email _____

Email appointment reminders? Yes ☐ No ☐

Birthdate _____ Age _____ M

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security # _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____

Relationship to Patient _____

Address _____

City _____ ST _____ Zip _____

Phone # _____

CLOSEST RELATIVE NOT LIVING WITH YOU:

Name _____

Address _____

City _____ ST _____ Zip _____

Phone # _____

DENTAL INSURANCE

Primary Dental Insurance Company

_____

Employee: _____

Employee Address: _____

Employee Phone Number: _____

Employee Date of Birth: _____

Employee Social Security: _____

Employer: _____

Group Number: _____

ID #: _____

SECONDARY DENTAL INSURANCE

Secondary Dental Insurance Company

_____

Employee: _____

Employee Address: _____

Employee Phone Number: _____

Employee Date of Birth: _____

Employee Social Security: _____

Employer: _____

Group Number: _____

ID #: _____

BROKEN APPOINTMENT FEE AGREEMENT

EFFECTIVE JANUARY 1, 2016

Given the fact that a period of time has been set aside with the doctor to see you and SPECIFICALLY YOU our office policy states that a broken appointment fee of $45.00 will be assessed to you, in the event that you break your scheduled appointment with the doctor without 24 hour prior notification to our office.

We understand that emergencies can and do occur, that is why the 24 hour window is open for you to change your appointment and reschedule for another time.

By signing this form you are saying that you have read, understand and agree to pay this fee should you choose to break your scheduled appointment.

Signature: _____ Date: _____

Relationship to patient: _____