

Welcome to Dr. Laurene Grabill's office. We appreciate you choosing our office for your dental needs. Please be assured that we will work hard to continually earn the trust you have placed in us. In order for us to serve you better, Please take a few minutes to complete this information form as thoroughly as possible.

Today's Date _____

PLEASE TELL US ABOUT YOURSELF

Patient's Name _____

Home Phone _____

Address _____

Cell Phone _____

City _____ State _____ Zip _____

Date of Birth _____ Sex M F

e-mail address _____

Social Security Number _____

Who may we thank for referring you to us for care _____

Do you have dental insurance _____

If the patient is a minor, please tell us about you, the parent or guardian:

Your name: _____

Relationship to Patient _____

Address _____

Your Home Phone Number _____

City _____ State _____ Zip _____

Your Social Security number _____

EMPLOYER INFORMATION

Employer Name _____

Business Phone _____

Employer Address _____

Your Position _____

City _____ State _____ Zip _____

How long with company _____

SPOUSE INFORMATION

Spouse's Name _____

Spouse's Social Security Number _____

Address _____

Spouse's Date of Birth _____

City _____ State _____ Zip _____

Business Phone _____

Spouse's Employer _____

How long with company _____

INSURANCE INFORMATION

Name of Insurance Company _____

Plan name or number _____

Name of Policyholder _____

Group Number/Effective Date _____

Social Security Number of Policyholder _____

Policyholder date of birth _____

Insurance Identification number _____

Authorization for Treatment: this is to certify that I, the undersigned Patient or Guardian, consent to all dental procedures agreed to between myself and Dr. Grabill, including the use of local anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Dr. Grabill, at her discretion, may elect to assess me finance charges, not to exceed 10% per month on any balances that are over 30 days past due.

Patient/ guardian Signature _____ Date _____