



WELCOME.....

(PLEASE PRINT)

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please read and complete each of the following sections. If the Patient is a minor under the age of 18 years, a Parent/Guardian **MUST** complete and sign the final section. The Guarantor **MUST** be 18 years or older. The better we communicate, the better we can care for you. And **thank you...** for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at anytime, please ask us. We will be happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the COG and the ADA.

.....The Doctors and Staff of Roberts Family Dental, P.C.

Section A – Patient Information

(Please Print)

Today's Date: _____

Name (First/Mi/Last) _____

Sex: Male Female Title: Mr. Mrs. Ms. Dr

SSN#: _____ Birthdate: _____

Home Address: _____

Apt#: _____ City/St/Zip: _____

Telephone No: Home # _____

Work # _____

Cell # _____

E/Mail Address: _____

Employer: _____

If you are a **Full Time** college student, list the School's Name:
 (City/State): _____

Section B – the Guarantor

Parent/Guardian to complete this section - ONLY if Patient is a **MINOR** or **FULL TIME** College Student.

Guarantor Name _____

Sex: Male Female Title: Mr. Mrs. Ms. Dr

Relationship to the Patient: Parent Legal Guardian

SSN#: _____ Birthdate: _____

Home Address: _____

Apt#: _____ City/St/Zip: _____

Telephone No: Home # _____

Work # _____

Cell # _____

E/Mail Address: _____

Section C – Patient Insurance Information

(Please check **ONLY** one)

No Changes

Yes, my dental insurance information has changed. **If yes, please provide us with your new insurance information.**

Section D – Patient Allergy ALERT

NO CHANGES

Section E – Patient Medical History

NO CHANGES

Section F – Female Patients ONLY

(Please check)

Are you currently... **No Yes**

1. Pregnant? If yes, how many weeks? _____

2. Nursing?

3. Taking birth control pills OR other hormones?

Section G – Intent to Pay

As the **Guarantor/Insured Party** (*herein referred to as I/us/my*) of this account, and for anyone enrolled under or added to this account, I hereby, guarantee payment to the office of Roberts Family Dental, or a representative of, Roberts Family Dental, for services rendered by the doctor and/or his agents; to us. I understand the doctor is acting in good faith by agreeing to perform said services prior to payment and this acts as my guarantee to pay the doctor in full for all services rendered. In the event payments are not received as agreed upon, I understand that a 1-1/2% late charge (18% APR) may be added to my account. I have read and understand the office policies stated and agree to accept financial responsibility as described, for all services rendered, for myself and for anyone enrolled under or added to my account.

 Guarantor's Signature (MUST be 18 years or older)

Date (Month/Date/Year)

Last Rev Date: 2008-03-22