First Name_____ Last Name_____ Middle Initial_____

Preferred Name_____ Social Security #_____

Single ___ Married ___ Widowed___ Divorced___ Date of Birth_____

Address_____ City _____State_____ Zip_____

Home# _____ Work # _____ Cell # _____

Employer_____ Address _____

E-mail _____

Spouse Name _____ Spouse Cell Phone _____

Spouse Employer _____ Work # _____

Spouse E-mail _____

Referred By _____

Local Emergency Contact _____ Relationship _____

Phone # _____ Phone # _____

Dental Insurance Information (If Applicable)

Primary

Name of Insured _____ SS#/ ID # _____

Relationship to Patient _____ Date of Birth _____

Employer _____ Insurance Company _____

Address _____ City _____ State _____ Zip_____

Home # _____ Cell # _____ Work # _____

Secondary

Name of Insured _____ SS#/ ID # _____

Relationship to Patient _____ Date of Birth _____

Employer _____ Insurance Company _____

Address _____ City _____ State _____ Zip_____

Home # _____ Cell # _____ Work # _____

I authorized Dr. Wiener's office to leave a message on Home Phone or my Cell Phone regarding appointments.

Signature _____ **Date** _____

Please be advised, you are financially responsible for all business conducted in our office. If you have dental insurance, please provide us with proof of coverage and we will be happy to file your insurance. You must pay your estimated percentage on each visit. In the event there is a balance once your insurance pays, you are required to pay that balance in full at that time. After 60 days there will be a service charge of 1.5%. In the event your account is turned over to collections, you agree to pay all collection fees and court cost.

Signature of Responsible Party _____ **Date** _____