DR SANDRA GOMEZ-TRAINOR

PATIENT INFORMATION FORM

DATE_____

NAME_____MARRIED_____SINGLE_____

ADDRESS_____
STREET APT# CITY STATE ZIP

EMAIL ADDRESS ----------

TELEPHONE (___) _____CELL_____WORK_____

DATE OF BIRTH _____SOCIAL SECURITY #_____

PLACE OF
EMPLOYMENT_____ADDRESS_____

DENTAL
INSURANCE_____GROUP#_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? OR HOW DID YOU HEAR ABOUT US?_____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?___

FAMILY INFORMATION
(FATHER/HUSBAND-WIFE/MOTHER)
NAME_____S.S.#_____

ADDRESS _____
STREET APT # CITY STATE ZIP

TELEPHONE#_____

PERSON TO CONTACT
IN CASE OF EMERGENCY
(FAMILY/ FRIEND)

NAME_____
TELEPHONE#_____

PERSON RESPONSIBLE
FOR ACCOUNT
PATIENT___PARENT____OTHER____

METHOD OF PAYMENT

CASH_____CHECK_____VISA_____
M/C_____DISC_____AMEX_____

OUR FINANCIAL POLICY:

ALL PATIENTS MUST COMPLETE OUR 'PATIENT INFORMATION FORM'.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECK, & MAJOR CREDIT CARDS.
- WE DO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT HISTORY.