

JASON AANENSON, DDS, PC

Patient Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SSN _____ Email Address _____

Place of Employment _____ Business Phone _____

Physician's Name _____ Phone _____

Address _____

Spouse/Parent/Guardian _____

In Case of Emergency Call _____ Phone _____

Person Responsible for Payment _____

Method of Payment _____ Cash _____ Credit Card _____ Insurance _____

Referred By _____

1. This clinic accepts patient applications from all people, regardless of sex, age, race, religion, color, ethnic origin, or disability status.
2. It is important for you to keep your appointments. Please notify the office at least one day in advance if you are unable to keep your appointment.
3. Services are provided on a pay as you receive service basis unless other arrangements have been made in advance. Charges not covered by insurance are the responsibility of the patient. Accounts over 30 days are subject to a 1.5% monthly finance charge.

I, the undersigned (patient or legally responsible party), authorize dental treatment and assume financial responsibility for the treatment to which I agree. My signature constitutes my acceptance of these policies.

Patient/Guardian Signature _____ Date _____