PATIENT INFORMATION

Last Name | First Name | Middle | Birth Date | Sex

Address | City | State | Zip

Home Phone | Work Phone | Ext. | Social Security Number

Employer | Occupation

Employer's Address | City | State | Zip

Spouse's Name | Parent or Guardian | Who May We Thank for Referring You

Person to Call in Case of Emergency | Relationship | Telephone

PERSON RESPONSIBLE FOR PAYMENT

Last Name | First Name | Middle | Relationship

Address | City | State | Zip

Home Phone | Work Phone | Ext. | Drivers License Number

Employer's Name | Social Security Number

Employer's Address | City | State | Zip

Is the patient covered by Dental Insurance? [ ] YES [ ] NO If YES, please complete the light green page

Thank you for completing the above information. To prevent any misunderstandings we want to be able to be as clear as possible regarding your treatment, our fees and your financial responsibility. Please read the following information carefully regarding our financial policy.

FINANCIAL AGREEMENT: I agree to pay all fees and charges for services the day they are incurred, unless previous arrangements have been agreed upon. Balances not cleared as agreed are subject to a Late Payment Fee of 1 and ½ % per month (18% per annum) until paid in full or the account is brought current as previously agreed.

TREATMENT CONSENT: I hereby authorize Dr. Chin to administer any treatment, medications or therapy, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of the above patient. I understand that the doctor, prior to commencement of treatment, will give a full explanation of the procedures.

I have read, understand and agreed to the above terms and conditions.

Signature of Patient/Parent/Guardian | Date

Terry Chin D.M.D. **4801 J Street, Suite D Sacramento Ca 95819**
(916) 451-4856