ATTENDING DR. ___________________________ CHART NUMBER ______________________

PATIENT INFORMATION

PATIENT		STREET ADDRESS	
CITY & STATE	ZIP CODE	HOME PHONE #	BUSINESS PHONE #
WHO REFERRED YOU TO THIS OFFICE?	GENERAL DENTIST	HOW LONG HAVE YOU BEEN A PATIENT OF GENERAL DDS?	
SOCIAL SECURITY #	DATE OF BIRTH	AGE	GENDER: FEMALE ☐ MALE ☐
EMPLOYER	EMPLOYER STREET ADDRESS / CITY / STATE / ZIP	OCCUPATION	

RESPONSIBLE PERSON INFORMATION

RESPONSIBLE PERSON'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY #	
STREET ADDRESS (IF NOT THE SAME)	CITY	STATE / ZIP	HOME PHONE
EMERGENCY CONTACT AND PHONE NUMBER (IF DIFFERENT)	EMPLOYER		
STREET ADDRESS / CITY / STATE / ZIP	BUSINESS PHONE	OCCUPATION	

Because of the nature of referral work, we must respectfully request that all patient balances be paid upon completion. If unable to do so, please advise us now. Time payments are available only through MasterCard, Visa, Discover Card, Amex or Care Credit.

Charges not paid within 30 days will have a service charge of 0.58% per month (Annual rate of 7%) added to the past due balance on each monthly statement thereafter.

Our usual and customary fee schedule on file with dental insurance companies, State of Michigan:

Service	Fee
Consultation and Exam	90.00
Anterior Root Canal	845.00
Bicuspid Root Canal	975.00
Molar Root Canal	1110.00
Retreat Anterior Root Canal	1070.00
Retreat Bicuspid Root Canal	1200.00
Retreat Molar Root Canal	1335.00
Surgery (including retrograde fill)	1410.00
Surgical Biopsy Removal	375.00
Incision & Drainage	125.00
First Film	30.00
Each Additional Film	26.00
Pulp Testing	55.00
Bleaching	300.00
Nitrous Oxide	75.00
Emergency Treatment Only	300.00

I, the undersigned, being the patient, parent or guardian state the above information is true to the best of my knowledge and understand that I am ultimately responsible for any charges incurred.

SIGNATURE ______________________ DATE ______________________