Dr. Henry T. Louie Inc.

Patient and/or Guardian – Please fill out completely as possible.

Date: _____ **Received** ☐ **Referral slip**
☐ **Telephone only**
☐ **Radiographs**

Name: _____ **Birthdate:** _____
(Day/Month/Year)

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **E-mail:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Employer: _____ **Occupation:** _____ **Business Phone:** _____

Spouse's Name: _____ **Employer:** _____ **Business Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Family Physician: _____ **Location:** _____ **Phone:** _____

Whom may we thank for referring you? _____

Are you available on short notice if there is a change in our schedule? ☐ **Yes** ☐ **No**

What is your present dental problem/concern? _____

Do you have dental insurance? ☐ **Yes** ☐ **No**

First Plan Name: _____ **Group Number:** _____ **ID No:** _____

Second Plan Name: _____ **Group Number:** _____ **ID No:** _____

☐ ***I understand that the total payment of the dental service is my responsibility and not that of the Insurance Company.***

☐ ***In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I understand accounts are payable as services are rendered. Accounts over 90 days are subject to a 2% per month interest charge.***

☐ ***I understand that I must provide 48 hours notice of cancellation or a $75.00 charge may be incurred.***

Signature: _____ **Date:** _____

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.