

WELCOME!

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to ask.

Date _____

Patient Information

Name _____
Last First Middle Initial

Address _____ Phone _____

City _____ State _____ Zip Code _____

Sex F M Age _____ Birth date _____ Soc. Sec. _____ - _____ - _____

Please check if you would like to receive E-mail correspondence E-mail address _____

Patient Employed by _____ Bus. Phone _____

Business Address _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance Information

Person Responsible For Account _____
Last First Middle Initial

Relation to Patient _____ Birth date _____ Soc. Sec. _____ - _____ - _____

Address (if different from patients) _____ Phone _____

City _____ State _____ Zip Code _____

Person Responsible Employed by _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Secondary Insurance Information

Is patient covered by additional insurance? _____

Person Responsible For Account _____
Last First Middle Initial

Relation to Patient _____ Birth date _____ Soc. Sec. _____ - _____ - _____

Person Responsible Employed by _____ Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Patient acknowledgments:

- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by Dr. Nicole Leiker in scientific papers or demonstrations, and patient education.
- I consent to the publication of my photos released to Dr. Leiker by other healthcare providers.
- I understand that all charges incurred, and not covered by dental insurance, are payable at the time of service.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

Signature _____ Date _____