

Kristy K. Vetter D.D.S.

31371 Niguel Road Suite #F, Laguna Niguel, CA 92677
Phone: (949)248-5205 Website: Drvettersmiles.com

Please Complete the following Confidential Information

Date _____

Getting to Know You

Patient: _____ Age: _____ Spouse's Name: _____
Last name First name Middle name

If patient is a minor, give parent's or guardian's name: _____ Relationship: _____

Mailing Address: _____

Married Single Divorced Separated Widowed Residential Phone: (____) _____ Cell: (____) _____

Driver's License #: _____ Social Security #: _____ Birthdate: _____

Employer: _____ Occupation: _____ Date Employed: _____

Business address: _____ Business phone: _____

Spouse Employed By: _____ Occupation: _____ Date Employed: _____

Spouse's S.S.#: _____ Spouse's Birthdate: _____ E-Mail: _____

Name of Nearest Relative not living with you _____ Relationship: _____

Complete Address: _____ Phone: (____) _____

How did you hear about our office? _____

Who can we thank for referring you? _____

Is another member of your family or relative a patient at our office? _____

If so who? _____

Person to contact in case of emergency: _____

Relationship: _____ Phone number: (____) _____

Address: _____

INSURANCE

Primary Carrier:

Insurance Co: _____

Employee: _____

Union or Local # _____

Group # _____

Date Employed: _____

S.S.# _____

Secondary Carrier:

Insurance Co. _____

Employee: _____

Union or local # _____

Date Employed: _____

S.S.# _____

Preference of Payment

- Cash on day of treatment Visa # _____
 Check Dental Fee Plan (Dental Credit Card)
 MasterCard # _____ Other

Person Responsible for this Account: _____

Address: _____ Phone: _____

Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all services are charged directly to the patient, and that he or she is personally responsible for payment of all dental services not paid by the insurance company. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 90 days. I agree to pay the reasonable value of all dental services rendered by the doctor in this office.

Consent for Treatment

I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this health history form to administer any dental treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all the possibilities complications of the procedures, anesthetics and/or drugs.

Signed _____ Date _____

Relationship to patient _____

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