Kristy K. Vetter D.D.S.
31371 Niguel Road Suite #F, Laguna Niguel, CA 92677
Phone: (949)248-5205 Website: Drvettersmiles.com
Cell #_____
e-mail_____

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: (___)_____

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:_____

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:_____

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:_____

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.#_____

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_____