

DR SANDRA GOMEZ-TRAINOR

PATIENT INFORMATION FORM

DATE_____

NAME_____MARRIED_____SINGLE_____

ADDRESS_____

STREET APT# CITY STATE ZIP

EMAIL ADDRESS -----

TELEPHONE (____) _____ CELL_____ WORK_____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

PLACE OF EMPLOYMENT _____ ADDRESS _____

DENTAL INSURANCE _____ GROUP# _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? OR HOW DID YOU HEAR ABOUT US? _____

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE? _____

FAMILY INFORMATION (FATHER/HUSBAND-WIFE/MOTHER)

NAME _____ S.S.# _____

ADDRESS _____

STREET APT # CITY STATE ZIP

TELEPHONE# _____

PERSON TO CONTACT
IN CASE OF EMERGENCY
(FAMILY/ FRIEND)

NAME _____
TELEPHONE# _____

PERSON RESPONSIBLE
FOR ACCOUNT
PATIENT___ PARENT___ OTHER___

METHOD OF PAYMENT
CASH___ CHECK___ VISA___
M/C___ DISC___ AMEX___

OUR FINANCIAL POLICY:

ALL PATIENTS MUST COMPLETE OUR 'PATIENT INFORMATION FORM'.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECK, & MAJOR CREDIT CARDS.
- WE DO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT HISTORY.