William A. Vainer, D.D.S.
2100 S. Bascom Avenue, suite #2
Campbell, CA 95008
Tel. (408) 377-9772

Date: _____

PATIENT'S NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

CELL PHONE#: _____ HOME PHONE#: _____ WORK PHONE#: _____

BIRTHDATE: _____ WHOM MAY WE THANK FOR REFERRING YOU? _____

ARE YOU A FULL TIME STUDENT? YES NO IF YES, SCHOOL: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

CELL PHONE#: _____ HOME PHONE#: _____ WORK PHONE#: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ OCCUPATION: _____ NUMBER OF YEARS: _____

DRIVER'S LICENSE #: _____ SSN: _____ BIRTHDATE: _____

SPOUSE'S NAME: _____
LAST FIRST MI

SPOUSE'S ADDRESS (IF DIFFERENT): _____
STREET CITY STATE ZIP

EMPLOYER: _____ OCCUPATION: _____ NUMBER OF YEARS: _____

INSURANCE INFORMATION

SUBSCRIBER'S NAME: _____ SSN: _____BIRTHDATE: _____

INSURANCE COMPANY: _____ INSURANCE PHONE#: _____

GROUP#: _____ EMPLOYER/GROUP NAME: _____DUAL INSURANCE? YES NO

CREDIT POLICY:

Even though it is our desire to assist you in the settlement of your account, the ultimate responsibility for payment is yours. Having insurance does not relieve you of this responsibility. We will bill your insurance for you as a courtesy, however, this office cannot accept responsibility for collecting your insurance or negotiating a settlement on a disputed claim on your behalf. Although we strive to get accurate information from your insurance company regarding your benefits and coverage, situations may arise that are out of our control. Therefore, knowing and understanding your dental benefits is your responsibility. Payment is due in full at the time of service, unless prior financial arrangements have been made. Past due accounts are subject to a service charge, and accounts that are over thirty days PASTDUE may be sent to collections. There is a $50 charge for appointments not canceled 24 hours in advance.

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE: _____ DATE: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE #: _____

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I certify that I have read and understand the above information to the best of my knowledge. The health history questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____