Welcome

Oconomowoc Dental Center
James A. Michaels DDS

819 Summit Avenue Oconomowoc, WI 53066
(262) 567-7224 www.drmichaelsdentalcare.com

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please **fill out this form completely in ink**. If you have any questions or need assistance, please ask us, we would be happy to help.

Date: _____
How did you hear about our office?_____

PATIENT INFORMATION:

Patient Name: _____ Nickname: _____
Address: _____
City, State: _____ Zipcode: _____
Home Phone: _____ Cell Phone: _____
Birthdate: _____ Gender: Male / Female Married / Single
SS#: _____ E-Mail: _____
Employer: _____ Employer Phone #:_____
Driver's License #: _____

In the event of an emergency, person we should contact:
Name: _____ Phone #: _____

RESPONSIBLE PARTY INFORMATION
If different than above…Otherwise skip

Name: _____ Driver's License #: ____ _____
Address: _____
City, State: _____ Zipcode: _____
Home Phone: _____ Cell Phone: _____
Birthdate: _____ Gender: Male / Female Married / Single
SS#: _____ E-Mail: _____
Employer: _____ Employer Phone #:_____

AUTHORIZATION & RELEASE:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
I understand that payment is expected the day of service for all services, co-pays, and deductibles. If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services. In the case of default on payment of this account, I agree to pay collection costs and responsible attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. 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 dependants.

X_____ Date: _____
Signature of patient or parent/guardian, if a minor