Date _____

Please complete the following confidential information

William E. Larson, D.M.D.
3755 Murphy Canyon Rd., #D
San Diego, CA 92123
(858) 277-2999

Your Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Social Security # _____

Birthdate _____ Drivers Lic. # _____

Employer _____

Emp. Address _____

City _____ State _____ Zip _____

Work # _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed

❑ Student, Name of school _____
❑ Full-time ❑ Part-time

Referred to us by _____

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

Name _____

Person to contact for emergency _____

Phone # _____

Spouse

Name _____

Work # _____ Social Security # _____

Birthdate _____ Drivers Lic. # _____

Employer _____

Emp. Address _____

City _____ State _____ Zip _____

If this appointment is for your child, complete this portion

Child's Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Birthdate _____ Age _____

Grade _____ School _____

If your child's name and address are not the same as yours, please fill in the box to the left also.

Insurance

Primary Carrier

Insurance Co. _____

Insured _____

Union or local # _____ Aid or Group # _____

Member # _____ Policy # _____

Second Carrier

Insurance Co. _____

Insured _____

Union or local # _____ Aid or Group # _____

Member # _____ Policy # _____

Financial Obligation

It is customary for patients to pay for services in full with cash, check or credit card the day the services are rendered. If you need to make financial arrangements please talk with our financial secretary before your appointment.

On any treatment which involves our use of laboratory services, i.e., crowns, bridges, partial dentures, or dentures, we require half of the cost at the time the procedure is begun. The balance may be divided into monthly payments. Monthly accounting statements are mailed to our patients and on any balance owed over 60 days there will be 1.5% finance charge.

Dental insurance is meant to be an aid to help restore and maintain the mouth in optimal dental health. It has been our experience that dental insurance rarely provides you with 100% coverage. Regardless of the amount of coverage, the patient is financially responsible for services rendered. We are well versed regarding insurance and will do everything possible to help you obtain maximum benefits. We will be glad to assist you in filling out your claim.

We also ask that if you cannot keep a scheduled appointment that you please give us at least 24 hours' notice so that someone else may use your appointment time. There may be a charge for missed appointments.

Financial Arrangements

_____ down

_____ monthly

Patient Signature

_____

Any additional treatment will require new financial arrangements.

Authorization

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I here authorize the attending dentist to administer such medications and preform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The above information is correct to the best of my knowledge. I understand that dental services may include, but are not limited to, the use of local anesthesia, x-rays, medications, surgery and other treatment. Once explained to me, I authorize and give consent for the dental services that are necessary and advisable.

Signature of
Responsible party _____ Date _____

❑ Adult Patient ❑ Spouse ❑ other ❑ Relationship _____