PREVIOUS DENTIST_____PHONE#_____
ADDRESS_____CITY_____STATE_____ZIP_____

WHO SHOULD WE NOTIFY, OTHR THAN SPOUSE (OTHER THAN PARTENTS IF PATIENT IS A CHILD) IN CASE OF EMERGENCY?

NAME_____RELATIONSHIP_____
ADDRESS_____PHONE_____
CITY_____STATE_____ZIP_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PLEASE READ CAREFULLY AND SIGN

Although services may be covered by insurance, I understand that I am fully responsible for payment of care I receive. Insurance Coverage and Employee Benefits are a contract between the insured and the insurance company. Payment is expected, by both private and insurance carrying patients, at the time services are rendered, unless written arrangements are made in advance. I understand an administrative service charge of 1 ½ % or $ .50, whichever is greater, will be applied after 90 days to all unpaid balances. I authorize payment of benefits to be paid directly to Stacy R. Kanda, D.D.S on all services billed to insurance.

SIGNED_____DATE_____