

OWNER'S INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

Mr. * Mrs. * Miss * Ms. * Dr. *

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PH: (_____) _____ WK PH: (_____) _____

YOUR EMPLOYER _____

OTHER PHONE NUMBERS: (_____) _____ MOBILE/CELLULAR/PAGER

MAY WE CALL YOU AT WORK? YES NO What Hours? _____

Spouse / Agent / Other Information

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

YOUR EMPLOYER: _____ PH # (_____) _____

MAY WE CALL YOU AT WORK? YES NO What Hours? _____

OTHER PHONE NUMBERS: (_____) _____ MOBILE/CELLULAR/PAGER

PAYMENT INFORMATION

CASH VISA MASTERCARD CHECK CareCredit
DRIVERS LIC.# _____ Birth date: _____ SOC. SECURITY # _____

ARE YOU 65 YEARS OR OVER TO QUALIFY FOR A 6% DISCOUNT ON SERVICES?

YES NO

(PRESCRIPTIONS, SPECIAL ORDER ITEMS, LAB WORK & OUTSIDE SERVICES ARE EXCLUDED)

YOU WILL BE GIVEN AN ESTIMATE OF FEES FOR TREATMENT, HOSPITALIZATION OR SURGERY. IF YOU ARE NOT GIVEN AN ESTIMATE, PLEASE ASK FOR ONE BEFORE LEAVING THE OFFICE. A DEPOSIT WILL BE REQUIRED ON ANY TREATMENT OR SURGICAL PROCEDURE OVER \$200.00. PLEASE NOTE THAT WE DO NOT ACCEPT ANY PAYMENT PLANS OR SECOND PARTY CHECKS.

RETURNED CHECK FEE IS \$25.00 IN ADDITION TO THE AMOUNT OF THE CHECK
ACCOUNTS SIGNED OVER TO COLLECTIONS ARE SUBJECT TO ADDITIONAL FEES IN ACCORDANCE TO THE CALIFORNIA CIVIL CODE.

SIGNATURE OF OWNER OR AGENT

DATE

**24 HOUR CANCELLATION NOTICE ON OFFICE VISITS AND
48 HOUR CANCELLATION NOTICE ON ALL SURGICAL PROCEDURES IS APPRECIATED**