Ola J. Englund, D.D.S.
Robert R. DesRoches, D.D.S.

PATIENT INFORMATION

Patient Name: ____ Birth Date: ___ /___ /____ Title: ____________
Preferred Name (Nickname):_________________ Sex: M / F Marital Status: S/M/D/W
Mailing Address: ________________________________ City: __________________ State: ______ Zip: ________
Home Phone: _________________ Cell Phone: ______________ E-Mail Address:_________________________
Best way to contact you: home/cell/work/email Referred by: __________________
Employer: _______________________________ Work Phone: _______________________ May we call you at work? _______
Spouse Name: ________________________ Children's Names:____
Nearest Friend or Relative not residing with you: ____________________________________ Phone: ____________

PRIMARY DENTAL INSURANCE

Subscriber Name: __________________________________ Relationship to Patient: __________________________
Birth Date: ____/____/____ ID #_________________________Employer:___________________________________
Insurance Company: ____ Group #___________________
Insurance Address: __________________________ City: ____________________ State: ______ Zip: __________

SECONDARY DENTAL INSURANCE

Subscriber Name: __________________________________ Relationship to Patient: __________________________
Birth Date: ____/____/____ ID #________/____/________Employer:______________________________________
Insurance Company: ____ Group # __________________
Insurance Address: ___________________________ City: ____________________ State: ______ Zip: _________

ACCOUNT INFORMATION

Account Guarantor: ____ Relationship to Patient: ______________
Preferred billing method:
□ By mail: Address: ________________________________ City: ______________ State: ______ Zip:_________
□ Online: Email address: _________________________________

We are committed to providing the highest quality dental care available to all of our patients. We are pleased to offer these alternatives to make our services affordable. Please choose one of the following:

□ Personal Credit Card
Visa/Mastercard
Discover/American Express

□ Cash or Personal Check

□ Outside financing is available through Care Credit.
Apply at: 800-365-8295 or
Online at: carecredit.com

I agree that I am fully responsible for the total payment of all procedures performed in this office - this includes any treatment that is not a benefit of any dental insurance that I may have. Estimated patient portion is due when services are rendered. One (1%) per month interest (12% per year) will be charged on accounts 90 days from treatment date.

____ ______________________________
Signature (Parent or Guardian) Date

"Expect exceptional care with honesty, integrity and love."