Adult Patient Form

Leipnitz Dental

Today's Date_____

Name_____

Address_____
City State Zip

Home Phone_____ Cell Phone_____ Mobile Carrier_____ Text Y / N

Email_____

Birth date_____ Social Security#_____ Sex M / F

Whom may we thank for referring you? _____

Employed by_____

Occupation_____

Business Address_____
City State Zip

Business Phone_____ Business Email_____

Dental Insurance Company_____

Insurance Company Address_____

Group / Policy / ID #_____

Name of Spouse_____

Birth date_____ Social Security #_____

Cell Phone_____

Employed by_____

Occupation_____

Business Address_____
City State Zip

Business Phone_____ Business Email_____

Dental Insurance Company_____

Insurance Company Address_____

Group / Policy / ID #_____

Acceptable Methods of Payment Available:
***Discount of 5% when payment in full, day of service**
***MasterCard, Visa, Discover, American Express**
Ask our staff about prearranged monthly billing on credit card
***Finance charge of 1 ½ % per month is computed on any balance not paid within 30 days.**
***Finance charge free plan**
Ask our staff for information