Brion Weinberg, DDS, FAGD
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Juno Beach, FL 33408
(561)622-7220
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Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE

How do you wish to be addressed? _____ Marital Status _____

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Birthdate _____ SS# _____

Employer _____ Occupation _____

If patient is a minor, give parent's or guardian's name _____

Has a friend or family member ever been to our office? Yes _____ No _____

If yes, their name _____

Whom may we thank for referring you to our office?_____

CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he sees fit. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered. I further understand that a 1.5% finance charge (18%) annually will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Signature

I authorize the release of information to all my insurance carriers. I understand that I am responsible for my bill.

NAME_____ DATE _____

SIGNATURE _____

(PLEASE CONTINUE ON THE OTHER SIDE)