Clifford W. Gross, D.D.S.

Big Oak Family Dentistry

PATIENT NAME_____

PATIENT ADDRESS_____ CITY_____ STATE/ZIP_____

NAME OF SPOUSE_____ HOME PHONE_____ WORK PHONE_____

PATIENT EMPLOYED BY (OR PARENT)_____ CITY_____ STATE/ZIP_____

PATIENT SOCIAL SECURITY #_____ SPOUSE SOCIAL SECURITY #_____

SPOUSE EMPLOYED BY_____ CITY_____ STATE/ZIP_____

SPOUSE WORK PHONE_____ REFERRED BY_____

NAME OF DENTAL INSURANCE CARRIER_____

ID #_____ GROUP #_____ AGREEMENT #_____

NAME OF SPOUSE DENTAL INSURANCE CARRIER_____

ID #_____ GROUP #_____ AGREEMENT #_____

PATIENT DATE OF BIRTH_____ SPOUSE DATE OF BIRTH_____

E-MAIL ADDRESS:_____

DO YOU HAVE A HEART MURMUR? _____

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

I understand that I may incur an **18%** finance charge if my balance goes beyond **30 days.**

I assign dental benefit payments to be paid directly to Dr. Clifford W. Gross from my insurance company.

I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.

X_____
PATIENT OR PARENT SIGNATURE

699 Doloro Drive ■ Morrisville, PA 19067 ■ (215) 295-1251