

**DAVID A. GOLDWYN, D.D.S., P.C.**

*Practice Limited to Periodontics and Implants*

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Portland, Oregon 97219-3999

Telephone 503-245-0180  
FAX 503-452-3634

**WELCOME TO OUR OFFICE.** Completion of this form in its entirety is **required** at time of visit.

Patient Name \_\_\_\_\_ Social Security # (required) \_\_\_\_\_

How would you like to be addressed? \_\_\_\_\_ General Dentist \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ Marital Status - Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_

Home Address \_\_\_\_\_ City & Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Parent \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

**In case of EMERGENCY:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Unless specific arrangements have been made with Office Manager, please indicate how you intend to pay:**

\_\_\_\_ For patients with dental insurance, 25% of total amount is due on the day of treatment.

\_\_\_\_ For patients without insurance. Payment **IN FULL** is required at each appointment. A 5% discount is available if paid by check or cash. (Sorry no discount if paid with credit card, due to credit card transaction fees.)

\_\_\_\_ Payment in full by Visa or MasterCard.

**Insurance information must be complete in order for us to bill them. Please give front desk a current copy of card.**

Primary Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_ Birth date of Subscriber \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_ Employer \_\_\_\_\_

Name of Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Birth date \_\_\_\_\_

**PLEASE READ CAREFULLY, AND SIGN BELOW:**

I verify that the above is true and correct. I acknowledge full responsibility for payment of all services. I understand that finance charges of 18% annually will be added to balances over 90 days old. I authorize release of information necessary to process insurance, and authorize my insurance carrier (if applicable) to issue dental payments directly to David A. Goldwyn, D.D.S. There will be no charge for appointments that are rescheduled at least 48 hours in advance.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE