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

Practice Limited to Periodontics and Implants

2350 S.W. Multnomah Blvd.
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