



**JONATHAN THOMAS** DDS  
*Smiles with Aloha*

**C O N F I D E N T I A L P A T I E N T I N F O R M A T I O N**

# Aloha

Patient# _____
Social Security# _____
Date _____

**P A T I E N T I N F O R M A T I O N**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Mobile# \_\_\_\_\_ Home# \_\_\_\_\_

Employer \_\_\_\_\_ Work# \_\_\_\_\_ Check Appropriate Box: SINGLE  MARRIED

**R E S P O N S I B L E P A R T Y**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Mobile# \_\_\_\_\_ Home# \_\_\_\_\_

Employer \_\_\_\_\_ Work# \_\_\_\_\_ Address \_\_\_\_\_

**HOW DID YOU LEARN ABOUT US?**

FRIEND  YELP  GOOGLE

Is This Person Currently A Patient In Our Office? YES  NO

**WHOM MAY WE THANK FOR REFERRING YOU?**

\_\_\_\_\_

**P A Y M E N T O P T I O N S**

**FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.**

**PAYMENT IN FULL IS DUE AT EACH APPOINTMENT**

PLEASE MARK THE PAYMENT OPTION YOU PREFER

CHECK  CASH  CARE CREDIT  MASTERCARD  VISA  I WISH TO DISCUSS PAYMENT POLICY

**AUTHORIZATION AND RELEASE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE KNOWLEDGE TO THE BEST OF MY KNOWLEDGE.

THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS TO THIRD PARTY PAYORS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.



**DATE:** \_\_\_\_\_