SKYVIEW
FAMILY DENTAL

This Acquaintance Form will help us to serve you better. We will do our best to make your appointments as convenient and pleasant as possible. Please free free to ask our staff if you have questions regarding your treatment, your appointments, or fees. We are glad you are here!

PLEASE PRINT

Mr / Mrs / Miss: ______________________________ Birthdate: ____________________
First Middle Initial Last Month / Day / Year

Home Phone Number: ______________________ Soc. Sec. #: ______________________

Home Address: ______________________________ City & Zip: ____________________

E-mail Address: ______________________ Cell Phone: ______________________

Employer: ____________________ Work Address: ______________________

Work Phone: ____________________ Present Position: ______________________

Spouse's Name: ______________________ Soc. Sec. #: ______________________

Employer: ______________________ Birthdate: ______________________

Work Phone: ____________________ Work Address: ______________________

Dental Insurance Co: ______________________ Insured's Employer: ____________________

Insurance Co. Address: ______________________ Phone #: ______________________

Group or Plan #: ______________________ Subscriber ID #: ____________________

BILLING

Person Responsible for Bill: ____________________ Birthdate: ______________________

Relationship to you: ______________________ Soc. Sec. #: ______________________

Billing Address: ______________________ City & Zip: ______________________

Emergency Contact: ______________________ Phone: ______________________

Relationship to you: ____________________ Whom may we thank for referring you to us? ____________

APPOINTMENTS: We work by appointment only so your wait will be minimal and your treatment done efficiently. To help us serve you better we ask for 2 business days notice for changes in your appointment. Not showing or canceling same day may result in a fee and possible loss of future appointment privileges.

INSURANCE: To avoid misunderstanding regarding dental insurance, we want our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

______________________________ ______________________
Signature Date