THOMAS J MUNGER III, D.D.S., P.C.

PATIENT INFORMATION

______________________ ______________________ __________/__________
PATIENT'S LAST NAME FIRST HOME PHONE NO CELL PHONE

____
HOME ADDRESS CITY STATE ZIP HOW LONG

____
MAILING ADDRESS, IF DIFFERENT THAN ABOVE CITY STATE ZIP

SOCIAL SECURITY NO ________________________ BIRTHDATE__________________ YOUR HOBBIES_______________

____
SPOUSE'S NAME / BIRTH DATE PARENT'S NAME

______________________ ______________________________________
YOUR EMPLOYER/FATHER'S EMPLOYER OCCUPATION YEARS WITH FIRM

______________________ ________________ ________________
EMPLOYER'S ADDRESS CITY OFFICE PHONE NO.

______________________ ______________________________________
SPOUSE'S EMPLOYER/MOTHER'S EMPLOYER OCCUPATION

______________________ ________________ ________________
EMPLOYER'S ADDRESS CITY OFFICE PHONE NO.

____ ________________
NEAREST RELATIVE NOT LIVING WITH YOU (Name) HOME TELEPHONE NO.

____
STREET CITY STATE ZIP

______________________ ______________ ________________
PHYSICIAN'S NAME CITY DATE OF LAST PHYSICAL

______________________ ______________ ________________
FORMER DENTIST'S NAME CITY DATE OF LAST VISIT

______________________ __________________________________
DRIVER'S LICENSE NUMBER WHOM MAY WE THANK FOR REFERRING YOU TO US?

______________________ ________________
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? SOCIAL SECURITY NUMBER

FOR PATIENTS WITH DENTAL INSURANCE

______________________ __________ ________________
INSURANCE SUBSCRIBER NAME BIRTH DATE SOCIAL SECURITY NO.

______________________ ______________ ________________
INSURANCE COMPANY NAME OF PLAN PLAN NO.

__________________ ____ ______________ ________________
HOW MUCH IS YOUR DEDUCTIBLE? WHAT IS YOUR YEARLY MAXIUMUM? SECONDARY INSURANCE

______________________ ______________ ________________
INSURANCE COMPANY NAME OF PLAN PLAN NO.

PERMIT FOR OPERATIONS

This is to certify that I, the undersigned, consent to the performing of the dental, medical and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated.

__________________________ ____________
PATIENT'S (PARENT'S) SIGNATURE DATE