Dr. Peter W. Piché and Dr. Spencer W. Olson

335 E State Street
Traverse City, MI 49684
(231) 947-2716

CONFIDENTIAL PATIENT INFORMATION

Patient
Name:_____Date:_____
First Middle Last Preferred name

Residence address:_____
Number Street

_____ Home Phone:_____
City State Zip Code Area Code Number

Cell phone/pager:_____ E-Mail address:_____
Birth date:_____ Social Security#_____
Patient Occupation:_____Employer:_____
Business Address:_____Business Phone:_____Ext:___
Marital status:_____Name of Spouse:_____Birthdate:_____
Spouse's Employer:_____Business Phone:_____Ext:__
Business Address:_____
Street City State Zip Code

Person Responsible for Account:_____
Whom may we thank for referring you to our office?_____
What method do you prefer for confirming your appointments? Calling: Y / N home
Y / N work Y / N cell phone or E-mail Y / N.

CONSENT FOR SERVICES

- Full payment is expected at time of service.
- All accounts over 90 days will accrue 1.5% per month finance charges.
- Visa and MasterCard accepted.
- Special payment arrangements can be made with our Financial Coordinator.

I will allow Dr. Piche' to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

PATIENT'S SIGNATURE_____Date:_____

DENTAL INSURANCE INFORMATION

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare insurance forms, however, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
If you have any type of dental insurance, please complete following. If you have dual insurance please complete both primary and secondary sections.

Primary:	Secondary:
Name of Subscriber:_____	Name of Subscriber:_____
Name of Dental Plan_____	Name of Dental Plan_____
Group #_____	Group #_____
SS#/or contract#_____	SS#/or contract#_____
Subscriber's Birth date:_____	Subscriber's Birth date:_____
Subscriber's address:_____	Subscriber's address:_____
Employer:_____	Employer:_____

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