ACQUAINTANCE FORM

Sue Kim Vetter, D.D.S.

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Birthdate: _____ Age: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Business Phone: _____ Ext:_____

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Person responsible for account: _____

I would like to receive correspondences via email_____ phone_____

How did you hear about Dr. Vetter? _____

Whom may we thank for this referral? _____

Spouse/Partner's Name: _____Birth date: _____

Employer: _____ Occupation: _____

Business Phone: _____

If a minor, parent or guardian's name: _____

Dental Insurance Company: _____Group No.: _____

Company Address: _____City/State/Zip: _____

Social Security Number/Insurance ID Number: _____

Subscriber's Name: _____ Effective date of dental insurance: _____

Do you have dual coverage? _____YES _____NO

If Yes:

Dental Insurance Company: _____Group No.: _____

Company Address: _____City/State/Zip: _____

Social Security Number/Insurance ID Number: _____

Subscriber's Name: _____Effective date of dental insurance: _____

In case of emergency please notify: Name: _____ Phone: _____

CONSENT: The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated and further authorize consent that the doctor choose and employ such assistance as she deems fit. I hereby authorize my insurance benefits to be paid directly to the doctor. I authorize the doctor to release any information required to process this claim. I also understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. In the event of default, I (we) promise to pay legal interest on the indebtedness together with such collection costs as may be required, to effect collection of this note.

Signature of Patient or Guardian: _____ Date: _____