Alicia Matayoshi DMD
7807 Baymeadows Rd. E. Suite 304

Patient Information

Patient Name:_____Birth Date: ____/____/____ Social Security #_____-____-_____

Address:_____ City_____State_____ Zip _____

Home Phone: (____) _____ - _____ Cell Phone: (_____) _____ -_____

Gender: Male ___Female___ Patients Email:_____

Patients or Parents Employer_____ Work Phone (____) _____ -_____

Emergency Contact_____ Relation_____ Phone (_____) _____-_____

Whom may we thank for your referral:_____

Insurance Information

Name of Insured_____ Relation to Patient_____

Birthdate ____/____/_____ Social Security # _____-____-_____

Employer_____ Work Phone: (____) _____ - _____

Insurance Company_____ Group#_____ Union or Local_____

Address_____ City_____ State_____ Zip_____

Insurance Company Phone # (____) _____ - _____

Secondary Insurance

Name of Insured_____ Relation to Patient_____

Birthdate ____/____/_____ Social Security # _____-____-_____

Employer_____ Work Phone: (____) _____ - _____

Insurance Company_____ Group#_____ Union or Local_____

Address_____ City_____ State_____ Zip_____

Insurance Company Phone # (_____) _____ - _____

Any missed appointments without 24 hours notice, except in an emergency, will result in a $45 charge to the patient. These charges are due and payable within 30 days.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I recognize and accept responsibility for payment of services not covered by Insurance benefits. I understand that I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at the time of service. We accept cash, checks, debit card and most major credit cards, including a dental finance plan. I agree to be responsible for payment of all services on my behalf or my dependents, should the account be referred to an agency or attorney for collection.

The undersigned shall pay reasonable attorney's fees and collection expenses.

PATIENT OR PARENT/GUARDIAN SIGNATURE_____ DATE:____/____/____