Fomich Family Dentistry, L.L.C.

701 W. Central Ave.
Delaware, Ohio 43015
740-362-6381

❑ Patient Information

Date of Birth _____-_____-_____ Soc. Sec. # _____-____-_____
First Name _____ M.I. ____ Last Name_____
Street Address _____
City _____ State _____ Zip _____
Primary phone ____ _____-_____ Secondary phone ____ _____-_____
Email: _____
Sex: Male or Female Marital status: Married Divorced Separated Widowed Single

Whom should we contact in case of an Emergency?
Name _____ Phone Number _____
Whom should we thank for your referral to our office? _____

Responsible Party Information (Whose account do we charge?)

Who is the responsible party? Self Spouse Father Mother Other
(Please answer if different from above)
Name _____ Soc. Sec. # _____-____-_____
Date of Birth _____-_____-_____ Employer _____
Home phone (___) ____-_____ Work phone (___) _____-_____
Address _____
City _____State_____ Zip _____

❑ Primary Dental Insurance Information

Policy Holder _____ Relationship _____
Date of Birth _____-_____-_____ Soc. Sec. # _____-____-_____
Employer _____ Ins. Company _____
Group Name _____ Group # _____
Ins. Co. Address _____

❑ Secondary Dental Insurance Information

Policy Holder _____ Relationship _____
Date of Birth _____-_____-_____ Soc. Sec. # _____-____-_____
Employer _____ Ins. Company _____
Group Name _____ Group # _____
Ins. Co. Address _____

I hereby authorize Jason Fomich, D.D.S., to render dental services and to release any information regarding any claim for insurance benefits. I agree to be responsible for any debts arising from such treatment. I agree to pay all attorney fees, collection agency fees, and court costs involved in the collection of any debts. If this debt is not paid within 60 days of the date of treatment, I agree to pay a service charge of one and one-half percent (1 ½ %) with a minimum of $2.00 per month unless other arrangements are made.
Patient/Parent or Guardian Signature_____ Date_____