

Gary G. Wolfson, D.D.S.

14000 E. Arapahoe Rd. #C-310

Centennial, CO 80112

(303)632-3622

wolfsondental@msn.com

www.wolfsondental.com



## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:  Last  First  MI  Preferred Name

Title:  Mr/Ms/Mrs/etc Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:  Prev. Visit:  Email Address:

Phone:  Home  Work  Ext  Mobile Best time to call:

Address:    
 City  State  Zip Code

Social Security # :

Whom may we thank for referring you to our practice?

☐ Patient ☐ Dental Office ☐ Internet ☐ Insurance List  
☐ School ☐ Work ☐ Other:

Name of person, office, or other source referring you to our practice:

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## Spouse or Responsible Party Information For Child

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name:      
Last First MI Preferred Name

Title:  Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other  
Mr/Ms/Mrs/etc

Birth Date:  Email Address:

Phone:     Best time to call:   
Home Work Ext Mobile

Address:    
    
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:  Phone:

Address:    
    
City State Zip Code

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## Primary Insurance Information

### Primary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

Insurance Phone #:

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## Secondary Insurance Information

### Secondary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

Insurance Phone #:

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## Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

I understand that all dental services are charged directly to the patient and that I am personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Interest will apply for any balance over 60 days and authorize Dr. Wolfson to obtain a credit report.

I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of diagnosis.

I understand and agree to pay any collection fees and all costs of reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your staff members, to telephone me to discuss my account or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: \_\_\_\_\_

Date:

Relationship to Patient:

Response Date: