

Kenneth B Rundle, DDS

Patient Name _____ Date _____

Address _____ Home Phone _____

_____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Birth Date _____ Social Security # _____ Email _____

Employer _____ Occupation _____

Employer Address _____

Spouse Name _____ Spouse Birthdate _____

Spouse Social Security # _____ Spouse Cell Phone _____

Spouse Employer _____ Spouse Work Phone _____

If Patient is a Minor, Person Responsible for Account _____

Dental Insurance: Yes No Name of Carrier _____

Name of Primary Insured _____ Group Number _____

What is the nature of this dental appointment? _____

How did you hear about our office? _____

To the best of my knowledge, the questions on this form have been accurately answered. I agree to inform Cosmetic Dentistry of Lake County & Highland Dental Care of any additional medical conditions as I become aware of them

I (WE) THE UNDERSIGNED, AS GUARANTOR AND AGENT OF THE ABOVE MENTIONED PERSON OR ENTITY SO HEREBY AGREE TO PAY ALL CHARGES INCURRED AS WELL AS ANY REASONABLE ATTORNEY'S FEES MENTIONED WITHIN 90 DAYS OF THE TIME SERVICES ARE RENDERED. I FURTHER AGREE THAT ANY DISPUTE WITH REGARD TO PAYMENT OF THIS DEBT SHALL BE SUBJECT TO THE LAWS OF THE STATE OF INDIANA AND BY MY SIGNATURE ON SUBMITTING MYSELF TO THE JURISDICTION OF THE COURTS OF INDIANA.

Signature Date

Patient's Name