Raymond Munz DDS, PC Date: _______________

Name: _____________________________________ Name you go by:______________
First Middle I. Last

Mailing address with city, state & zip code: ____

Phone Numbers: Home _______________ Work ______________ Cell _________________

DOB: ________________________ Social Security #: _____________________

E-mail Address: ____

Martial Status (Circle One): Single Married Divorced Other

Employer: ____

Previous Dentist: ____

Policyholder Name: _________________________ Employer:___________________

Dental Insurance Carrier: ____

Ins Co. Address: ____

ID# ____________________ Group#: ______________ DOB: ______________

Other Contact Information:

Name:____________________________________ Relationship: ______________

Phone Numbers: Home _____________________ Cell _____________________

How did you hear about our practice? _________________________________

How may we help your smile today? ______________________________________

If you wear dentures, when was the current plate(s) made: Date: _________________

FINANCIAL POLICY

In the event that your payment is returned to Dr. Munz's office and not repaid within 10 days you will be charged interest of 1½ % per month (18% APR) from date of service. Also any balance over 30 days will have interest applied. You will also be responsible for collection and reasonable attorney fees (deemed to be 33%).

Signature: ____