Clifford S. Litvak M.S., D.D.S.
ESTHETIC COMPREHENSIVE DENTISTRY

Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Phone Numbers: _____
HOME BUSINESS

Age-Yrs: _____ Birthdate: _____ Birth Place: _____

Social Security Number (if child, parent's): _____

Driver's License Number: _____

Occupation: _____ Employer: _____

Address: _____
STREET CITY STATE ZIP

Person responsible for bill: _____

Address: _____
STREET CITY STATE ZIP

Relationship: _____ Social Security Number: _____

Occupation: _____ Employer: _____

Address: _____
STREET CITY STATE ZIP

Phone Numbers: _____
HOME BUSINESS

Insurance Information

Insured person's full name: _____ Work phone: _____

Social security number: _____ Relationship to patient: _____

Insurance Company Name: _____

Group Name _____ Group Number: _____

Employer Name: _____

Full Address of Employer: _____
STREET CITY STATE ZIP

Getting to know you

Why did you select our office? _____

Whom may we thank for referring you? _____

Is another member of your family or a relative a patient in our practice? _____

Emergency contact: _____ Phone: _____

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctore and/or his staff. I agree to pay for all services rendered by this office.

_____
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE