MARTIN N. HIKIDO, D.D.S.

PLEASE PRINT THE FOLLOWING

This Information is Important for our Records and Your Health

Patient's Name ☐ Mr. ☐ Miss ☐ Mrs. ______________________________
Last First Middle Initial

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Other

Birth Date ____________

Residence Address ______________________ City ____________ Zip ______

Residence Phone ______________________ Date of Last Dental Visit ____________

Referred By: ______________________________

Physician's Name ______________________ City ____________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name ______________________ Relationship ____________

Place of Employment ______________________ Business Address ____________

Occupation ______________________ Business Phone ____________

DENTAL INSURANCE:

Name of Company ______________________

Group No. ______________________

Identification No. ______________________

Subscriber ______________________

Social Security No. ______________________

OFFICE POLICY ON PROFESSIONAL FEES

A. Emergency services performed strictly on a cash basis.

B. All other dental services are cash unless financial arrangements are made.

Date ____________ Signature ______________________