

**Goodwin Dentistry & Medicine**  
**3025 Aloma Avenue Winter Park, Florida 32792**  
**Please Print**

**Patient Information**

**Referred By**

Last Name	First	Nickname	Sex	Marital Status
Date of Birth	Social Security Number	Home Phone	Cell Phone (May we send you text) <span style="float: right;">yes <input type="checkbox"/> no <input type="checkbox"/></span>	
Address	City/State	Zipcode	E Mail Address	
Employer	Work Phone		Occupation	

**Responsible Party/Spouse**

Last Name	First	Nickname	Sex	Marital Status
Date of Birth	Social Security Number	Home Phone	Cell Phone	
Mailing Address (If different than above)				

Employer	Work Phone	Occupation
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**Primary Dental Insurance**

Policy Holder's Name	Date of Birth	Social Security number	Relation to Patient
Policy Holder's Address	Home Number		Work Number
Employer	Group Number	ID Number	

Insurance Company	Phone Number	Mailing Address
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**Secondary Dental Insurance**

Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Policy Holder's Address	Home Number		Work Number
Employer	Group Number	ID Number	

Insurance Company	Phone Number	Mailing Address
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To avoid being charged for the loss of time we ask for the courtesy of a 24-hour notice for any change to appointments. This will allow another patient who needs the appointment time to make use of it. Payments are required for all services at the time they are rendered. We accept cash, check, Care Credit, and most major credit cards. As a courtesy to our patients with insurance, we will file claims and accept assignment when allowed. You will be responsible for all deductibles and co-pay portions at the time of the visit. If payment has not been received from your insurance company within 30 days, the balance will be sent to you for prompt payment. Any balance that goes over 90 days will be subject to interest charges of 18% APR.

I give my consent to the performing of dental procedures that have been agreed to be necessary or advisable. This may include the use of local anesthetic and/or nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I understand that the information I have given today is correct to the best of my knowledge. I authorize the release of information necessary to process my claim. I also authorize payment of dental benefits to Dr. Goodwin. I have read and understand the above information.

Patient/Guardian Signature	Date
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