

HARBOUR DENTAL
Michael E. Krone D.D.S.
Patient Registration Form

Name _____ Home# _____

Address _____ DOB _____

City _____ State _____ Zip Code _____ Cell# _____

Employer _____ Phone # _____

SS# _____

Spouse/Parent _____ DOB _____

SS# _____ Employer _____

E-Mail Address _____

Nearest Relative Not Living With You _____ Home# _____

Family Physician _____ Telephone# _____

Whom May We Contact In An
Emergency? _____ # _____

Whom May We Thank For Referring You? _____

What Are Your Interest Or Hobbies? _____

I am responsible for full payment of my account for any professional services rendered. Upon non-payment or any default, all obligations are hereunder including all attorney fees in the amount of 33-1/3% of the total indebtedness. If this indebtedness is not paid in full within 90 days, I agree to pay a handling charge of 1-1/2% a month, 18% per annum. I also understand that all appointments made by me are my responsibility, and without 48hr notice (2 days) I may be charged a minimum of \$25.00. I have read all of the information above and completed this form to the best of my knowledge.

Patient
Signature _____ Date _____

Responsible Party _____ Date _____