

**WELCOME TO THE OFFICE OF  
Michael A. Peele, DDS**

We follow ALL HIPPA GUIDELINES in protecting your privacy whereas ALL of your private information is kept STRICTLY CONFIDENTIAL. Our office does not provide in office monthly payments, however we do offer Care Credit which allows monthly interest free payments (if approved by Care Credit). If interested, please speak to the office manager prior to your treatment so we can have you fill out an application to see if you are approved.

Regarding cell & land line numbers; any phone number your provide us is giving us prior consent to call those numbers when needed.

**PATIENT INFORMATION (Please print clearly & complete ALL questions)** If your prefer not to give us your SS# we understand, if so we do require payment in FULL at time of services, your SS# is to secure your account balance.

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First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ - - \_\_\_\_\_ Married, Single, College Student, Child  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

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Employer's Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(IF A COLLEGE STUDENT) Part-Time, Full-Time \_\_\_\_\_  
College Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(IF MARRIED) \_\_\_\_\_  
Spouse's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

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Full Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**RESPONSIBLE PARTY (Check here if same as patient ) FILL OUT ONLY IF DIFFERENT FROM PATIENT. Regarding responsible part of minors – the parent who brings the minor child to the appointment is considered the responsible party & will be responsible for all co-pays at time of service. (Regarding court orders; we cannot get involved in court orders between parents: Payment needs to be made at time of service and court portions settled between parents.)**

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First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

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Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ - - \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_