



Lou Gallia MD, DDS, FACS

PATIENT'S NAME _____		Preferred Name _____	
Address: _____		City: _____	State: _____ Zip: _____
Telephone: home _____		work _____	other _____
SSN: _____	Driver's Lic: _____	DOB: _____	Age: _____

EMPLOYER: _____ Occupation: _____ How long? _____
 Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY (if under 18) _____ Relationship? _____
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: home _____ work _____ other _____
 SSN: _____ Driver's Lic: _____ DOB: _____ Age: _____

SPOUSE: _____ SSN: _____
 Employer: _____ Occupation: _____ How long? _____
 Address: _____ City: _____ State: _____ Zip: _____

Nearest Relative Not Living w/ you: _____ Telephone: _____
 Address: _____ City: _____ State: _____ Zip: _____

WHO MAY WE CONTACT IN AN EMERGENCY: _____ Phone: _____

YOUR PHYSICIAN: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

YOUR DENTIST: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

HOW DID YOU HEAR ABOUT US? _____

REASON FOR THIS VISIT? _____

APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept definite arrangements for appointments. Once an appointment is made, please note this time is reserved for you. **AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS NECESSARY. OTHERWISE A CANCELLATION CHARGE WILL BE MADE.** A finance charge of 1.5% a month will accrue on account balances due over 30 days.

PATIENT INFORMATION