Jeffrey P. Fisher, DDS

"Anesthesia for Little People"

Patient Scheduling Form

Fax this completed form to 530-888-8263 Problems? Call 916-832-1091.
Security code (3-digits on back of card) required for credit card payments.

Appointment Date: ______________________ Day: __________________ Dr. Fisher's Arrival Time: ____________

Dentist Name/City: ____________________________ Tel: (____)_____________ Scheduling Manager:_________________

____:____ Begin Time
Patient:______________________________ DOB:______________ Age:_______ Gender:______ Wt:_______
Parent:______________________________ Home Tel: (_____)_____-_______ Work/Cell: (_____)_____-_______
Comments: ____

Case Length
Deposit: Amount $________ Payment Method: ☐ Cash ☐ Check ☐ Care Credit ☐ Credit Card Other____________

____:____ Hrs. Mins. (Procedure + 45 min)
Credit Card #:________-________-________-________ Exp. Date: ____ / _____ 3-digit code (on back; required):______
Name on Card:______________________________ Card Type: ☐ VISA/MC ☐ AMEX ☐ DISC Other________
Billing Address (Required): ____ Zip: ________
! Medical Alerts ! ☐ No ☐ Yes ____

____:____ Begin Time
Patient:______________________________ DOB:______________ Age:_______ Gender:______ Wt:_______
Parent:______________________________ Home Tel: (_____)_____-_______ Work/Cell: (_____)_____-_______
Comments: ____

Case Length
Deposit: Amount $________ Payment Method: ☐ Cash ☐ Check ☐ Care Credit ☐ Credit Card Other____________

____:____ Hrs. Mins. (Procedure + 45 min)
Credit Card #:________-________-________-________ Exp. Date: ____ / _____ 3-digit code (on back; required):______
Name on Card:______________________________ Card Type: ☐ VISA/MC ☐ AMEX ☐ DISC Other________
Billing Address (Required): ____ Zip: ________
! Medical Alerts ! ☐ No ☐ Yes ____

____:____ Begin Time
Patient:______________________________ DOB:______________ Age:_______ Gender:______ Wt:_______
Parent:______________________________ Home Tel: (_____)_____-_______ Work/Cell: (_____)_____-_______
Comments: ____

Case Length
Deposit: Amount $________ Payment Method: ☐ Cash ☐ Check ☐ Care Credit ☐ Credit Card Other____________

____:____ Hrs. Mins. (Procedure + 45 min)
Credit Card #:________-________-________-________ Exp. Date: ____ / _____ 3-digit code (on back; required):______
Name on Card:______________________________ Card Type: ☐ VISA/MC ☐ AMEX ☐ DISC Other________
Billing Address (Required): ____ Zip: ________
! Medical Alerts ! ☐ No ☐ Yes ____

____:____ Begin Time
Patient:______________________________ DOB:______________ Age:_______ Gender:______ Wt:_______
Parent:______________________________ Home Tel: (_____)_____-_______ Work/Cell: (_____)_____-_______
Comments: ____

Case Length
Deposit: Amount $________ Payment Method: ☐ Cash ☐ Check ☐ Care Credit ☐ Credit Card Other____________

____:____ Hrs. Mins. (Procedure + 45 min)
Credit Card #:________-________-________-________ Exp. Date: ____ / _____ 3-digit code (on back; required):______
Name on Card:______________________________ Card Type: ☐ VISA/MC ☐ AMEX ☐ DISC Other________
Billing Address (Required): ____ Zip: ________
! Medical Alerts ! ☐ No ☐ Yes ____
