PATIENT INFORMATION

DATE			PREFERRED NAME
PATIENT NAME			
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
SOCIAL SECURITY #			
DATE OF BIRTH	AGE	(CIRCLE ONE) MALE FEMALE	(CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED
IS A FRIEND OR RELATIVE A PATIENT AT OUR OFFICE? ❑ YES ❑ NO IF YES, NAME	RELATIONSHIP:		IF MARRIED, SPOUSE'S NAME
WHO IS YOUR GENERAL DENTIST?		WHO REFERRED YOU TO OUR OFFICE?	
PERSON TO CONTACT IN CASE OF EMERGENCY			PHONE #
ADDRESS	CITY	STATE	ZIP

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

YOU		YOUR SPOUSE	
NAME		NAME	
OCCUPATION		OCCUPATION	
EMPLOYER		EMPLOYER	
BUSINESS ADDRESS	CITY	BUSINESS ADDRESS	CITY
BUSINESS PHONE	EXT	BUSINESS PHONE	EXT

INSURANCE INFORMATION

PRIMARY CARRIER - DENTAL		SECONDARY CARRIER - DENTAL	
INSURANCE COMPANY		INSURANCE COMPANY	
GROUP/LOCAL #		GROUP/LOCAL #	
EMPLOYEE	DATE OF BIRTH	EMPLOYEE	DATE OF BIRTH
EMPLOYEE SS #		EMPLOYEE SS #	
EMPLOYEE #	DATE EMPLOYED	EMPLOYEE #	DATE EMPLOYED

(continued on back)

CURRENT ❑

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)____’s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree that all past due amounts shall be charge 1.50% percent interest per month on the unpaid balance commencing sixty (60) days after billing. The undersigned accepts full responsibility and agrees to notify this office within 10 days of any change of address. The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us. Collection agency fees can be up to an additional 50% of the amount turned over for collection. In the course of collection of the amount due, an attorney may be engaged by this office or by the collection agency to help with the collection. The undersigned agrees to pay reasonable attorney fees, court costs and other costs paid or incurred by this office or our collection agency while collecting the amount due.

Patient Signature ____

Date ______________________________

Signature of Responsible Party ____