Michael J Vilag DDS

Patient Name: ____
Last First Initial
Gender: __Male __Female
How would you like to be addressed? ________________________
Date of Birth: ______________________ __Married __ Single __Divorced __Minor
Age: _____ If Minor, Parents Name: _________________________
Address:____
Street apt# City State Zip
Phone: (Home) ________________ (Cell) ______________ (Business)________________
Other Family Members in this Practice:_______________________
Whom may we thank for this referral: ________________________
Someone to notify in case of emergency not living with you:
____

Insurance Information

Employee Name: ____
Relationship to patient: __________________ Date of Birth: _________________
Employer Name: ____
Phone: _____________________ Soc. Sec. #: ________________________
Address: ____
Name of Insurance Company: ___________________________________
Drivers License #: ____

Consent/Authorization

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist use and disclosure of my/my child's records to carry out treatment, to obtain payment, and for those activites and health care operations that are related to treatment or payment. My consent shall be effective until I revoke it in writing. **I consent to the disclosure of my/my child's records to the following persons who are involved in my/my child's care for payment for that care.**

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of all services not paid by my dental care payer.

I understand that photographs, x-rays, and other records may be taken during the course of my treatment. I give my permission for such items to be used for purposes of research, education, publication in professional journals, and/or website of Dr. Michael J Vilag. If you decline to consent to the use of these items please mark the following box & initial before signing this form.

☐ I decline consent for my photographs, x-rays, and other records. Initial______

Patient or Guardians Signature: ____________________ Date: ____________