Patient Information

Name: ______________________________ Birth date:________________

E-Mail Address: _________________________Home:________________ Cell Phone: ______________

Address: ________________________ City: ____________________ State: ____ Zip: ___________________

Patient Employer: ______________________________ Work Phone: _________________________________

Occupation: ____

Spouse or Parent's Name: _________________________ Work Phone: ______________________________

Whom May We Thank for Referring You? ____

Is this Person Currently a Patient in our Office? □ Yes □ No

Emergency Contact: ________________________________ Phone: __________________________________

Responsible Party

Name of Person Responsible for Account: ____________________ Relationship to Patient: _______________

Address: ____ Birth date: __________________

SS#: _______________________________ Home Phone: ________________________

Employer: ___________________________ Work Phone: __________________________

Insurance Information

Name of Insured: ____ Relationship to Patient: _______________

Birth date: _______________________ SS#: ____________________ Date Employed: ___________________

Employer: _______________________ Union/Local#: ____________ Work Phone: _______________________

Insurance Company: _______________ Group#: _________________ Policy/ID#: ________________________

Insurance Co. Address: _____________________ City: ___________ State: _______ Zip: __________________

Do You Have Additional Coverage? □ Yes □ No **If So, Please Complete Next Section**

Name of Insured: ____ Relationship to Patient: ________________

Birth date: _______________________ SS#: ____________________ Date Employed: ____________________

Employer: _______________________ Union/Local#: ____________ Work Phone: ________________________

Insurance Company: _______________ Group#: _________________ Policy/ID#: _________________________

Insurance Co. Address: _____________________ City: ___________ State: _______ Zip: ___________________

Informed Consent:

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, therapy, that may be indicated for ________________ (patient name), and further authorize and consent that the doctor choose and employ such assistance and he deems fit. I understand the use of anesthetic agents and certain treatments embody some risk. In good faith the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I understand that responsibility for payment for Dental Services provided in the office for myself or my dependents is mine and arrangements for payment will be made before initial treatment begins. I understand that a finance charge of 1.5% (18% annually) will be assessed if account is overdue 90 days. Breach of this responsibility carries the penalty of compensating the doctor's attorney and collection fees.

Signature of Patient: ____ Date: ____________________________