PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2

PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

Email:

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME			
RELATIONSHIP TO PATIENT			
ADDRESS			
CITY		STATE	ZIP
PHONE NO.			
YOU			
NAME			
OCCUPATION			
EMPLOYER			
BUSINESS ADDRESS		CITY	
BUSINESS PHONE NO.		EXT.	
YOUR SPOUSE			
NAME			
OCCUPATION			
EMPLOYER			
BUSINESS ADDRESS		CITY	
BUSINESS PHONE NO.		EXT.	

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:		RELATIONSHIP:
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

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 anesthetic, 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 to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that I will be responsible for all collection costs.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____