

PATIENT INFORMATION**CONFIDENTIAL**

Date _____

(Please Print)

Driver's Lic. # _____

Social Security # _____

Name _____ Birth date ____ / ____ / ____
First Middle LastAddress _____
City State ZIP

Home Ph. (____) _____ Work Ph. (____) _____ Cell Ph. (____) _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Patient is Student, Name of School / College: _____

Patient's or Parent's Employer: _____

Business Address _____
City State ZIPSpouse's or Parent's Name _____
Employer Work Phone Ext.Person (not living with you)
To contact in case of emergency: _____ Ph. (____) _____

Whom may we thank for referring you? _____ Ph. (____) _____

RESPONSIBLE PARTYName of person responsible for this account: _____ Patient here? Yes No

Relationship to Patient _____ Driver's Lic. # _____ Social Security # _____

Address _____
City State ZIP

Home Ph. (____) _____ Work Ph. (____) _____ Cell Ph. (____) _____

Birth date ____ / ____ / ____ Employer _____

Business Address _____
City State ZIP**INSURANCE INFORMATION**

Name of Insured: _____ Birth date ____ / ____ / ____ Relationship to Patient: _____

Social Security #: _____ Home Ph. (____) _____ Work Ph. (____) _____

Name of Employer: _____

Insurance Company: _____
Address City State ZIP
Group # Union or Local #Ins. Company Address: _____
City State ZIP

Name of Insured: _____ Birth date ____ / ____ / ____ Relationship to Patient: _____

Social Security #: _____ Home Ph. (____) _____ Work Ph. (____) _____

Name of Employer: _____

Insurance Company: _____
Address City State ZIP
Group # Union or Local #Ins. Company Address: _____
City State ZIP

RESPONSIBLE PARTY

Please Read and Initial

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of

(Name of patient) _____'s dental needs.

Initials

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.

Initials

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

Initials

Should the need arise, I **Agree** **Do Not Agree** to give my permission to discuss any or all of my treatment with family members such as (please circle as many that apply):

Spouse Parent(s) Significant Other Guardian Grandparents Aunt / Uncle Children Care Giver Sister / Brother

Other: _____

Initials

RESPONSIBLE PARTY

Please Read and Initial

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Initials

I understand that payment is due at the time of service. I also understand that in the event payments are not received by agreed upon dates, that a 1% - 1½% late charge (18% APR) may be added to my account.

Initials

I understand that in the event that I cancel an appointment without calling 48 hours in advance during regular business hours, I may be charged a fee of: \$75 for the Hygienist; \$150 per hour for the Doctor.

Initials

If you have insurance:

I understand that in the event that I have insurance, a claim for services rendered for my dental care will be filed to my insurance company as a courtesy to me. I also understand that Doctor and/or associates do not accept assignment of benefits and that as a result, my insurance company will reimburse monies owed to me for service rendered according to the benefits outlines within my insurance plan.

Initials

I understand that in the event that I have dental insurance coverage, my insurance plan may pay at a Usual, Customary and Reasonable rate as outlined within my dental plan coverage. (Please refer to your insurance benefits booklet for explanation.)

Initials

I give my permission to release my information to my insurance company in order to receive reimbursement / payment for services rendered by this office.

Initials

Patient or Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____

