

NAME _____ NICKNAME _____ D.O.B. _____
LAST FIRST M.I.

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SS # _____ GENDER _____ MARITAL STATUS _____

HOME # _____ WORK # _____ Ext _____ DRIVER'S LICENSE # _____

PAGER # _____ CELL PHONE # _____ BEST TIME TO CALL _____

E-MAIL ADDRESS _____ HOW DO YOU PREFERRED TO BE CONTACTED# _____

EMPLOYED BY _____ SINCE _____

PRESENT POSITION _____ SPOUSE'S FULL NAME _____

DATE OF BIRTH _____ SS # _____ WORK PHONE # _____

EMPLOYER _____ PRESENT POSITION _____ SINCE _____

BY WHOM WERE YOU REFERRED TO OUR OFFICE _____

NAME, ADDRESS, AND PHONE # OF NEAREST RELATIVE NOT LIVING WITH YOU:

PRIMARY INSURANCE INFORMATION

DENTAL INSURANCE COMPANY _____

MAILING ADDRESS _____

PHONE # _____ CITY STATE ZIP
GROUP / POLICY # _____

POLICYHOLDER (INSURED) _____ RELATIONSHIP TO PATIENT _____

SS # _____ WORK PHONE _____ DOB _____

EMPLOYER _____ PRESENT POSITION _____

SECONDARY INSURANCE INFORMATION

DENTAL INSURANCE COMPANY _____

MAILING ADDRESS _____

PHONE # _____ CITY STATE ZIP
GROUP / POLICY # _____

POLICYHOLDER (INSURED) _____ RELATIONSHIP TO PATIENT _____

SS # _____ WORK PHONE _____ DOB _____

EMPLOYER _____ PRESENT POSITION _____

PLEASE PROVIDE US WITH A COPY OF YOUR CURRENT DENTAL INSURANCE CARD

SEE OTHER SIDE FOR ADDITIONAL INFORMATION --- THANK YOU

CONSENT FOR TREATMENT & OFFICE POLICY AGREEMENT

1. I HEREBY AUTHORIZE THE 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 _____ 'S DENTAL NEEDS.
NAME OF PATIENT
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. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT TIME SERVICE IS RENDERED. IF REQUIRED, I ALSO UNDERSTAND A CHECK OF MY CREDIT HISTORY MAY BE MADE.
5. I UNDERSTAND THAT IF I CANCEL AN APPOINTMENT WITHOUT 48 HOURS ADVANCE NOTICE I WILL BE RESPONSIBLE FOR A \$ 25.00 CANCELLATION FEE.
6. I UNDERSTAND THAT EVEN IF INSURANCE IS INVOLVED I AM ULTIMATELY THE RESPONSIBLE PARTY. IF MY INSURANCE HAS NOT PAID WITHIN 90 DAYS I WILL PAY ALL CHARGES AND WAIT FOR REIMBURSEMENT FROM MY INSURANCE.
7. I AGREE TO BE RESPONSIBLE FOR ALL DENTAL SERVICES NOT PAID BY MY DENTAL BENEFITS PLAN. I FURTHER UNDERSTAND THAT THE INSURANCE BENEFITS QUOTED ARE AN "ESTIMATE" ONLY. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY CLAIMS AND AUTHORIZE PAYMENT DIRECTLY TO DR. LINDA SIERRA.

PATIENTS
SIGNATURE _____ DATE _____ WITNESS _____

THANK YOU FOR TAKING CARE OF YOUR CHARGES TODAY -- WE ACCEPT CASH, CHECK, CREDIT CARD: VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER.

RESPONSIBLE PARTY

FILL THIS OUT----ONLY IF PATIENT IS NOT THE RESPONSIBLE PARTY

NAME _____

ADDRESS _____

EMPLOYED BY _____ HOW LONG _____

HOME # _____ WORK # _____ RELATIONSHIP TO PATIENT _____