

INTRODUCTION / HISTORY

PLEASE PRINT

CHILD

PATIENT'S FULL NAME _____ NICKNAME _____

WHO MAY WE THANK FOR REFERRING YOU _____

DATE OF BIRTH _____ GENDER _____ SCHOOL & GRADE _____

FAVORITE SUBJECT _____ PET'S NAME _____ FAVORITE SHOW OR GAME _____

SPORTS OR HOBBIES _____ ANY PREVIOUS NEGATIVE DENTAL EXPERIENCES _____

IF YES, PLEASE EXPLAIN _____

HOME ADDRESS _____ CITY _____ ZIP _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

FULL NAME OF PARENT OR GUARDIAN _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ SS # _____ TxDL# _____ MARITAL STATUS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PAGER # _____ BEST TIME TO CALL _____ EMPLOYER _____

PRESENT POSITION _____ DATE OF HIRE _____

SPOUSE'S FULL NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ SS # _____ WORK PHONE _____

EMPLOYED BY _____ PRESENT POSITION _____

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

PRIMARY INSURANCE

DENTAL INSURANCE COMPANY _____

MAILING ADDRESS _____

PHONE # _____ CITY STATE ZIP
GROUP / POLICY # _____

POLICYHOLDER (INSURED) _____ RELATIONSHIP TO PATIENT _____

SS # _____ WORK PHONE _____ DOB _____

EMPLOYER _____

SEE OTHER SIDE FOR FURTHER INFORMATION --- THANK YOU

SECONDARY INSURANCE

DENTAL INSURANCE COMPANY _____
MAILING ADDRESS _____
PHONE # _____ CITY _____ STATE _____ ZIP _____
GROUP / POLICY # _____
POLICYHOLDER (INSURED) _____ RELATIONSHIP TO PATIENT _____
SS # _____ WORK PHONE _____ DOB _____
EMPLOYER _____

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

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 \$45.00 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. I FURTHER UNDERSTAND THAT ALL INSURANCE QUOTES ARE "ESTIMATES ONLY".
7. I AGREE TO BE RESPONSIBLE FOR ALL DENTAL SERVICES NOT PAID BY MY DENTAL BENEFITS PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY CLAIMS AND AUTHORIZE PAYMENT DIRECTLY TO DR. LINDA SIERRA.

PARENT or GUARDIAN
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.