We are complimented that you have selected us to provide dental care to you and your family

## ---------- Patient Information ----------

Date _____ Patients Name _____ _____
Last First Middle

(If patient is a full time student fill in school name) _____

Address _____
Street City State Zip

Home Phone _____Cell Phone_____Birthdate:_____Social Security_____

Email Address_____How often do you check email:_____Cell Phone Do you accept text msgs_____

If patient is a minor, give parenfs or guardian's name _____

Whom may we thank for referring you to our office? _____

Name of nearest relative not living with you _____

Complete Address _____ Home Phone _____

Cell Phone:_____Email Address:_____

## ---------- Responsible Party Information ----------

Name _____
Last First Middle Maritial Status

Residence _____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address _____Home Phone_____Cell Phone_____Work Phone _____

Previous Address if less than 3 years_____ Email:_____
Street City State Zip

Social Security # _____Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. Years Employed _____

Employer Address _____

Spouse's Name _____ _____ _____Relationship to Patient_____
**Last** **First** **Middle**

Employer_____ Occupation_____ No. Years Employed _____

Employer Address _____ E-Mail_____

Social Security #_____ Birthdate _____Cell Phone_____Work Phone _____

## ---------- Insurance Information ----------

Insured's Name _____ Insurance ID# or Soc. Sec. #_____

Insurance Company_____Group No_____Preferred or Nonpreferred Plan (circle)

Insurance Co. Address _____ Ph.# _____ _____

Is policy connected with your union? Yes __ No __ Name of Union _____Local No. _____

Do you have dual coverage? Yes __ No __ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____Insured's Soc. Sec. # _____

Insurance Co. _____Group No. _____ Local No. _____

Insurance Co. Address _____Ph.# _____

Insured's Employer _____Ph.# _____

**CONSENT:**

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) . I understand that using anesthetic agents embodies a certain risk. Futhermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____Witness_____

Parent or Responsible Party _____ Relationship to Patient_____

FOR OFFICE USE: Reviewed by Dr_____Date_____