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

Patient Information

Patient's Name_____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell _____ Work _____ Birth Date _____ Social Security # _____

If Patient is a minor, give parent's or guardian's name _____

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

Name of emergency contact — someone not living with you _____

Responsible Party Information

Name: _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ □ Rent □ Own Cell Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____
Street City State Zip

Spouse's Name _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Insurance Information

Subscriber _____ Birth Date _____ Soc. Sec. # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone _____

Employer _____ Phone _____

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**

Subscriber _____ Birth Date _____ Soc. Sec. # _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone _____

Employer _____ Phone _____

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 and authorizes the use of these records for teaching purposes, study groups and case presentations.
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. Furthermore, I authorize and consent that doctor choose and employ such assistant 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.
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.
6. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect the collection.
7. Appointment times are reserved exclusively for each patient. If you find the need to reschedule an appointment, **we require the courtesy of 48 hours notice**. A fee may be charged without sufficient notice to change an appointment.

Patient _____ Date _____ Witness _____

Parent of Responsible Party _____ Relationship to Patient _____