PATIENT INFORMATION

Name ______________________________ Nickname ______________________________

Address ____
Street City State Zip

email ____

Social Security # ______________________________ Birthdate ______________________________

Phones: Cell ____________________ Home ____________________ Work ____________________

Employer ____

Parent or Guardian (if patient is a minor) ____

DENTAL INSURANCE

Insured's Name ______________________________ Relationship to patient ____________________

Social Security # ______________________________ Birthdate ______________________________

Employer____

Insurance Company ______________________________________ PPO *or* DHMO
(circle one)

Subscriber ID______________________________ Group #______________________________

INFORMATION AND CONSENT

I hereby authorize doctor to take x-rays or other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. 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. I agree to the use of anesthetics or other medicines as necessary. I fully understand that dental treatment and anesthetic agents embody certain risks and that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APPR) may be added to my account.

Patient (Guardian) Signature ______________________________________ Date ____________________