We are complimented that you have selected us to provide dental care for you and your family
Whom may we thank for referring you to our office?__________________________.

PATIENT INFORMATION - *If patient is a minor give responsible party information*

Patient's name

Address:

STREET | CITY | STATE | ZIP

Previous Address if at this address less than three years.

Home Phone # ( ) | Social Security # - - | Drivers License #

Birthdate / / | *If patient is a minor give parent/guardian name*

Employer | Occupation | No of years employed?

Work Phone # ( ) | Employer Address

STREET | CITY | STATE | ZIP

SPOUSE'S INFORMATION

Spouse's Name | Relationship to patient

Spouse's Employer | Occupation | No of years employed?

Spouse's SSN # / / | Spouse's Birthdate / / | Spouse's Work Phone # ( )

Spouse's Employer Address

STREET | CITY | STATE | ZIP

If patient is a full-time student fill in school name

Name of nearest relative not living with you | Relationship

Complete address | Phone # ( )

In case of Emergency contact | Phone # ( )

INSURANCE INFORMATION

Insured's Name | Insured's SSN# / / | Insured's Birthdate / /

Insurance Company | Group No.

Insurance Company Address | Phone # ( )

Is this policy connected with your union Yes No | Name of Union | Local #

Do you have dual insurance coverage? Yes No ***If yes, please complete following Secondary Ins. Information***:

SECONDARY INSURANCE INFORMATION

Insured's Name | Insured's SSN # / /

Insurance Company | Group No. | Insured's Birthdate / /

Insurance Company Address | Phone # ( )

Is this policy connected with your union Yes No | Name of Union | Local #

CONSENT

1. The undersigned hereby authorizes doctor to take x-rays, study models,photographs, or any other diagnostic aids deemed appropriate by the 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. Furthermore, 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% (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 is my responsibility to advise your office of any changes in the information contained on this form.

6. I understand that there is a cancellation fee charge for appointments that are missed without 24 hours notice.

Patient | **Date** | **Witness**

Parent of responsible party | **Relationship to patient**

FOR OFFICE USE: Reviewed by Dr. | **Date**