WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Name _____ Date _____

Birthdate _____ Soc. Sec. # _____

Wishes to be called _____ Male O Fem O Minor O

Single O Married O Divorced O Widowed O Separated O

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ E-Mail _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Work Phone _____ Ext _____ Home Phone or Cell _____

Responsible Party

Who is responsible for the account?

Name _____ Relationship to patient _____

Birthdate _____ Driver's License # _____ Soc. Sec. # _____

Address _____

City, State, Zip _____

Occupation _____ Employer _____

Employer Address _____

Work Phone _____ Ext _____ Home Phone _____

Cell Phone _____ E-Mail _____

Payment

Please check the option which you prefer

Payment in full at each appointment by either: O Cash O Personal Check O Credit Card (MC VI AE DI)

I wish to discuss the dental office's policy _____

Referred by _____

Please complete reverse, also.

Dental Insurance Information

	Primary Insurance	Additional Insurance
Name of Insured		
Relationship to Patient		
Insured's birthdate		
Soc. Sec. #		
Employer		
Date Employed		
Occupation		
Insurance Company		
Group #		
Employee/Cert #		
Ins Company Address		

Standard Informed Consent

Informed consent:

I consent to treatment for preventative and restorative services offered by this office. By consenting to the treatments I acknowledge my willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Drugs and medications:

When medications are used I understand that side effects and allergic reactions are possible, no matter how slight the possibility.

Changes in treatment plans:

I understand that during treatment, while working on the teeth, it may be necessary to change or add procedures because of conditions found which were not discovered during the initial examination. I give permission to the dentist to make any or all changes and additions necessary.

Authorization and Release:

I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dental group any insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf.

X_____ Date _____

Signature of patient (or parent if minor)

Please complete reverse, also.