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

PATIENT INFORMATION

Name: _____ SS#: _____
Last First Middle Initial

Address: _____
Street City State Zip

Home No.: _____-_____ Cell No.: _____-_____ Office No.: _____-_____

Birth date: _____ /_____/_____ Age: _____ Male / Female Marital Status: _____

If Married name of Spouse: _____ Spouse Occupation: _____

Drivers License/ CAL ID: _____Email Address: _____

Employer: _____ Occupation/ Position: _____

Office Address: _____

Person to contact in case of an Emergency: _____ Phone No.: _____

Whom May We Thank for Referring You to Our Office? _____

PRIMARY INSURANCE

Name of Insurance Plan: _____ Group No: _____

Person Responsible for Account: _____ SS #: _____

Relation to Patient: _____ Birth date: _____

Insured's Employer: _____Bus. Phone No: _____

Do you have Secondary Insurance? _____ Name of Insurance Plan: _____

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 embody 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 arrangement 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 advice your office of any changes in the information contained on this form.

Patient _____ Date _____Witness _____

Parent or Responsible Party _____ Relationship to Patient _____