PLEASE COMPLETE THE FOLLOWING
CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

DATE:_____
PATIENT'S NAME:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE #:_____SS#:_____
BIRTHDATE:_____AGE:_____
(IF CHILD) GRADE:_____SCHOOL:_____
CELL PHONE_____ E-MAIL ADDRESS_____

RESPONSIBLE PARTY INFORMATION -- (INSURED PARTY)

NAME:_____
SPOUSE:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE:_____SS#:_____
BIRTHDATE:_____AGE:_____
PLACE OF EMPLOYMENT:_____
WORK ADDRESS:_____
WORK#:_____CEL#:_____
MARRIED:____ SINGLE:____ DIVORCED:____ WIDOWED:____
RELATIONSHIP TO PATIENT:_____

INSURANCE

PRIMARY CARRIER:			SECONDARY CARRIER:		
Last	First	M	Last	First	M
Birthdate(MO/DAY/YEAR)	Relationship to Patient		Birthdate(MO/DAY/YEAR)	Relationship to Patient	
Employer	Dental Ins. Co.		Employer	Dental Ins. Co.	
SS#	Group#		SS#	Group#	

DENTAL INSURANCE**

I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the dentist, therefore, **I am still responsible for all dental fees.** I understand that I will be charged for all dental treatment and that any payments received by the Dental Office from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred.

_____
Patient Signature (Parent signature if patient is under 18 years of age)

PERSON TO CONTACT IN CASE OF AN EMERGENCY
Outside of Immediate Family Household
NAME:_____
ADDRESS:_____
CITY/STATE/ZIP:_____
PHONE #:_____

Has any member of your family ever been treated in our office?

____YES ____NO

Whom may we thank for inviting you to our office?

_____

CONSENT
The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all form of treatment, medication and therapy that may be indicated in connection with (Name of Patient)_____and further authorize and consent that Doctor choose and employ assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge, 18% annually, will be added to any balance over 60 days. I understand that even though I have some type of insurance coverage, I am responsible for payments of services.

Preferred Method of Payment: ___CASH ___CHECK ____CREDIT CARD(Visa/MC/Disc/AmEx)

_____ _____
Today's Date Signature of Patient, or Parent, or Responsible Party

_____
State Driver's License #