WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare.
To help us meet all your 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

Date _____ Name _____

Wishes to be called _____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address _____

City, State, Zip _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Occupation _____

Referred by _____

Contact Information

Home Phone _____ Pharmacy Phone # _____

Work Phone _____ Ext. # _____

Mobile Phone _____ E-Mail _____

Where do you prefer to receive calls? ❑ Home ❑ Work ❑ Mobile

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact? Relationship _____

Name _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

Soc. Sec. # / I.D. # _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

Soc. Sec. # / I.D. # _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Address _____

City, State, Zip _____

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

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

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, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

X _____
Signature of patient or parent if minor Date

Authorization and Release

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

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

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

X _____
Signature of patient or parent if minor Date

Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

Payment in full at each appointment:

- ❑ Cash
- ❑ Personal Check
- ❑ Credit/Debit Card ___ Visa ___ Mastercard ___ Discover

❑ I wish to discuss the office's payment policy.