

# 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. # \_\_\_\_\_

Car Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Where do you prefer to receive calls?     Home     Work     Car

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. # \_\_\_\_\_

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. # \_\_\_\_\_

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.

Any outstanding balance may be charged to my credit/debit card.  Visa  Mastercard  Discover

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

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.