PATIENT INFORMATION:

Name ______________________ Age ________ Sex ☐M ☐F Home Phone ( ) ____________

Address ______________________ Apt. No. ______ Work Phone ( ) ____________

City ______________________ State ______ Zip ________ Other Phone ( ) ____________

Birthdate ____________ SSN ____________ Driver's License No. ____________ State ______

Employer/Occupation ______________________ Address ______________________

In Case of Emergency, Contact: ____________ Relationship ____________ Phone ( ) ____________

Are any of your family members patients of this practice? ☐ Yes ☐ No Name ____________ Relationship ____________

If the person responsible for the account is different from the patient, please fill in this section:

Name ______________________ Relationship ____________ Home Phone ( ) ____________

Address ______________________ Apt. No. ______ Work Phone ( ) ____________

City ______________________ State ______ Zip ________ Employer ____________

Birthdate ______________________ SSN ____________ Address ____________

PRIMARY DENTAL INSURANCE *(Leave blank only if no dental benefits)*

Name ______________________

Address ______________________

City ____________ State ______ Zip ________

Phone ____________ Group No. ____________

Policy Number ______________________

Name of Insured if different from patient:

Name ____________ Relationship ____________

Address ______________________

City ____________ State ______ Zip ________

Birthdate ____________ SSN ____________

Employer ______________________

SECONDARY DENTAL INSURANCE (Leave blank only if no dental benefits)

Name ______________________

Address ______________________

City ____________ State ______ Zip ________

Phone ____________ Group No. ____________

Policy Number ______________________

Name of Insured if different from patient:

Name ____________ Relationship ____________

Address ______________________

City ____________ State ______ Zip ________

Birthdate ____________ SSN ____________

Employer ______________________

PATIENT TREATMENT CONSENT

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- Some teeth may have hidden decay, or affected nerves, requiring more extensive dental treatment which could lead to additional charges.
- As a condition of treatment, financial arrangements must be made in advance. Patients who carry dental insurance must understand that all dental services provided will be billed directly to the patient's account and that he or she is personally responsible for the payment of all dental services regardless of "expected" dental insurance. I understand that I am responsible for any portion not paid by my insurance company regardless of an estimate I may have been quoted.
- As a courtesy, our office will assist in collection of your insurance benefits by filing necessary forms. However, our office will not assume responsibility for the lack of benefits paid. Your insurance company states "this is not a guarantee of benefits" when we call them, therefore we cannot offer a guarantee they will pay. This form also authorizes this Practice to submit insurance claim formsand receive payment directly from the Insurance Carrier with the notation"SIGNATURE ON FILE." I authorize my dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested. If you are concerned about this issue you can call your insurance company for details or refer to your policy manual prior to any dental treatment.

I have read and understand the above treatment regarding my dental treatment and my insurance benefits.

______________________ ____________

Patient/Financially responsible guardian Date