## Spouse Information or Parent (if minor)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Other: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Emergency / Secondary Contact Information (Not in the same household)

Name: _____

☐ Male ☐ Female ☐ Relationship: _____

Phone (Home): _____ (Work): _____ Ext: _____ Other: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

## *Dental* Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Insurance Company Name and Address: _____

_____

_____

Insurance Company Phone Number: _____

***PLEASE ADVISE IF YOU HAVE COVERAGE WITH MORE THAN ONE DENTAL INSURANCE COMPANY***

**I will be paying today by:** ☐ Cash ☐ Check ☐ Credit Card

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred for their care. Our office presently provides the service of filing your insurance at no additional fee, however the patient is responsible for the full cost of the treatment agreed upon.

I hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor as necessary to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon and to issue the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are made.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

I understand that all responsibility for dental services provided in this office for myself or dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

**I have read the above conditions of treatment and agree to their content.**

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian