Patient Information

(This information is necessary for our file and will be considered confidential)

Your Information:

Your Name: (Last/First/ MI): ____

Prefers to be called by: _____________________________________ Male ☐ Female ☐

Home Address: ____
Street City Zip

Home Phone: ( )_______________________ Cell Phone: ( )_______________________

Email Address: ____

Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Birthdate: _______________________ Social Security #: ____________________________

Your Employer: ___________________________________ Occupation: _________________________________

Business Address: ____Bus. Phone: ( ) ___________________
Street City Zip

Your Spouse's Name: ________________________ Birthdate: ___________

Your Spouse's Employer: ______________________________ Occupation: _________________________________

Business Address: ____ Bus. Phone: ( ) ___________________
Street City Zip

In Case Of Emergency Whom Should We Call? ____

Phone # of Emergency Contact: _____________________________ Relationship to Patient: __________________

Whom may we thank for referring you to our office? _________________________________

Minor Patient Information:

IF MINOR: Patients Name: (Last/First/ MI): ____

Prefers to be called: ____ Male ☐ Female ☐

Home Address: ____
Street City Zip

Home Phone: ( )_______________________

Email address: ____

Birthdate: _______________________ Social Security #: _________________

Financial Information:

Person responsible for Account: __________________________________ Relationship to Patient: _____________

Billing Address: ____ Telephone: ( ) ___________________
Street City Zip

Preference of Payment: Cash ☐ Personal Check ☐ Credit Card ☐ CareCredit ☐

(Primary Dental Insurance)

Name of Insurance Company: ________________________________

Group#: __________________________

Insured's ID#: ______________________

Employer Name: _______________________________

Insured's Name: ________________________________ Insured's Birthdate: ___________________________

Insured's relationship to patient: ________________________________

(Secondary Dental Insurance)

Name of Insurance Company: ________________________________

Group#: __________________________

Insured's ID#: ______________________

Employer Name: _______________________________

Insured's Name: ________________________________ Insured's Birthdate: ___________________________

Insured's relationship to patient: ________________________________

Consent for Treatment

1. 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 (name of patient) ___________________________________’s dental needs.

2. 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.

3. 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.

4. I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit history may be made.

6. Cell Phone: ☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.
   My Cell phone number is: (   ) ____________________________________.

Patient’s Signature ____
Parent/Responsible Party Signature ____
Relationship to patient ____
Date ____

Witness ____