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 _____