PATIENT INFORMATION

Date _____ Age _____
Name _____ Nickname _____
Address _____
City _____State _____ Zip _____
Phone (H) _____ (W) _____ Ext.____ Pager _____
Cell _____ E-Mail Address _____
Birth Date _____ Sex M F Marital Status S M D W
SSN# _____Drivers License# _____
Spouse/Parent Name _____
Full Time Student? Y N School _____
Patient Occupation _____
Patient Employer _____
Employer Address _____
City _____ State _____ Zip _____

Responsible Party Info (person that carries the dental insurance)

Name _____
Birth Date _____ SSN# _____
Employer Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Ext _____ Phone _____

Insurance Information

Primary Insurance	Secondary Insurance
Insured Name _____	Insured Name _____
Birth Date _____	Birth Date _____
SSN# _____	SSN # _____
Insurance Co. _____	Insurance Co. _____
Address _____	Address _____
City _____ State __ Zip _____	City _____ State __ Zip _____
Group No. _____	Group No. _____
Phone No. _____	Phone # _____

Who may we thank for referring you? _____
Reason for visit? _____

Consent for Treatment: This is to certify that I, Undersigned: (1) Consent to the performing of the Dental Procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated: (2) Consent to releasing information to my insurance company; and (3) Agree to pay the fees associated with the dental procedures, including the award of reasonable costs of collection agency fees (30%-50%) and attorney fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

_____ _____
Patient Signature Date Parent/Guardian Signature Date