Print Form

Patient Name	Social Security Number	Home Phone ( )
Home Addres	City, State, Zip	Cell Phone ( )
Email Address		Work Phone ( )
(Circle) Marital Status Single Married ☐ Divorced Separated ☐	MALE ☐ FEMALE ☐	Birthday / /	Drivers License and State

Primary Insurance Company…… Group……Subscriber…….

Secondary Insurance Company……Group……Subscriber…….

Responsible Party		
Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthday / /
(Circle) Marital Status Single Married Divorced Separated	Relationship To Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Bussiness Address	City	State Zip

Spouse's name	Social Security Number	Birthday / /
Spouse's employer	Spouse's Occupation	Spouse Work Phone ( )
Spouse's Bussiness Address	City	State Zip

How did you hear about our Office?

(Check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office?.....

Referred by a friend ……. Yellow pages…… Relative…….. Insurance Plan…….. WebSite……..……

Other…….. TV/Radio Ad…… Newspaper Ad……... Sing by Building……... Direct Mailing……..…

If you were referred, whom may we thnk for referring you?.....

Consent

I will answer all health questions to the best of my knowledge……(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above name's patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-ray as may be deemed necessary and advisable by the doctor.

…… ……..……..

Signature *Date* *Relationship to Patient*

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient: I hereby individually obligate myself to pay the account in accordance with the fees and terms of the Dental Office. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

INSURANCE RELEASE: I hereby authorize release of any information needed and also authorize my insurance copany to pay directly to This Office benefits accounting to me under my policy. I understand that in order to collect my debt, my credit history might be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amouts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasoble attorney's fees.

I grant my permission to you, or your assigns to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their consent.

SIGNED..... **DATE**…….

If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hours notice. We ask for this advance notice so that we can offer this appointment to another patient. A $ 40 fee will be charged if a patient does not show up for an appointment without 24 hours notice.....