



DATE: _____

NAME: _____

PREFERRED NAME: _____

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDAY ____/____/____ TELEPHONE _____
HOME OFFICE CELL

MARITAL STATUS: _____ E-MAIL ADDRESS: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____

SOCIAL SECURITY #: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY: _____

INSURANCE COMPANY'S TELEPHONE NUMBER: _____

POLICY HOLDER'S NAME: _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: ____/____/____

POLICY HOLDER'S EMPLOYER: _____

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize the 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. Lastly, 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 services.

PATIENT SIGNATURE _____ DATE ____/____/____

PARENT OR RESPONSIBLE PARTY _____

RELATIONSHIP TO PATIENT _____

