ACCOUNT INFORMATION

1. PATIENT

Date _____

Patient Name _____

Address _____

_____ Zip _____

Home Phone #_____

Work Phone #_____ Cell # _____

Birthdate _____ Age _____

Married_____ Single_____ Divorced_____ Widowed_____

2. PAYMENT

Name (if child, parent name)

_____ (DOB) _____

Mailing address _____

_____ Zip _____

Driver's License # _____

Social Security # _____

Occupation _____

Employer _____

Business Address _____

Business Phone #_____ Ext. _____

YOUR SPOUSE:

Name _____ (DOB) _____

Social Security # _____

Employer _____

Business Address _____

Business Phone #_____ Ext. _____

3. GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office?_____

Referred to us by_____

_____

_____

Person to contact for emergency

_____

Phone #_____

Closest relative not living with you

_____

Phone #_____

4. INSURANCE

Primary Carrier

Employer _____

Employee _____

Group # _____

Benefits _____

_____

_____

_____

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature _____ Date _____

Relationship to Patient _____