

SPOUSE OR RESPONSIBLE PARTY INFORMATION:

The following is for: the patient's spouse the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City State Zip Code

EMPLOYMENT INFORMATION:

The following is for: the patient's spouse the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION:

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID# : _____ Group # : _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID# : _____ Group # : _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

CONSENT FOR TREATMENT

- 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.
- 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.
- 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.
- 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.

Patient's Signature: _____ Date: _____ Witness: _____

Parent/Responsible Party's Signature: _____ Relationship to Patient: _____