RESPONSIBLE PARTY INFORMATION

The following is for the person responsible for payment.

Name:______________________________Relationship to patient:____________________

❑ Male ❑ Female

Social Security #:______________________ Date of Birth______________________

Phone (Home):________________ (Work):________________Ext:______Cell Phone:__________

Address: Street: ____________________________________Apartment #______________

City______________________State__________________Zip____________________

EMPLOYMENT INFORMATION

Employer Name:_____________________________ Phone: ( )___________________

Address: Street:__________________City:______________State:__________Zip:__________

INSURANCE INFORMATION

Primary

Name of Insured:__________________________________ Is Insured a patient? ❑ Yes ❑ No

Insured's Birth Date:________________________________ Group #__________________

Insured's Address:__________________________________Contract #________________

__________________________________S.S.#:________________

Insured's Employer Name:____

Address:____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other______________

Insurance Company and Address:____

____

Secondary

Name of Insured:______________________________ Is Insured a patient? ❑ Yes ❑ No

Insured's Birth Date:__________________ID #____________ Group #:______________

Insured's Address:______________________________Contract #:__________________

Insured's Employer Name:_________________________S.S.#:____________________

Address:____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other:______________

Insurance Plan Name and Address:_______________________________________

____

CONSENT FOR SERVICES

The undersigned hereby authorized Doctor to take X-rays, 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 in connection with (Name of Patient)______________________________________ 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 unless financial arrangements have been made. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient______________________________Date__________Witness________________

Parent or Responsible Party______________________Relationship to Patient______________

HEALTH HISTORY REVIEWED______________