PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____

Telephone # Hm: (___) _____ Wk: (___) _____ E-mail: _____

Employer's Name & Address: _____ Occupation: _____

_____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: Name, Address & Phone # of a friend or a relative not living with you: _____

_____

_____

DENTAL INSURANCE INFORMATION

Dental Insurance Company: _____ Telephone #: (__) _____

Address: _____ City/State: _____ Zip: _____

Insured Employee: _____ Date of Birth: _____ Relationship to Patient: _____

Employer (Name & Address): _____

Employee Social Security #: _____ Group Policy #: _____

I authorize the release of any information to my insurance company necessary to file a claim:

Signature: X _____

CONSENT FOR TREATMENT

I hereby authorize the doctors 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 of my dental needs and to perform any and all forms of treatment to include medication and therapy. I understand the use of anesthetics embodies a certain risk. 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.

I hereby certify that I have read and fully understand consent for treatment.

Signature of Patient or Guardian: X _____ Date _____