About You:

Full Name :______________________________ Preferred Name:____________________

Address:______________________________ City/State/Zip: ____________________

Phone number: ________________Social Security #:____________________ Birth Date:__________

Employer: ________________________ Email:______________________________

Are you: Married Single Widowed Spouse Name: ____________________ Birth Date:________

Phone number: ________________ Employer: ______________________________

Emergency contact: ____________________*Phone:* ____________________ *Relation:*________

*Address:*______________________________ *City/State/Zip:*____________________

Party Financially Responsible (Minors)

Name:______________________________ Address:______________________________

Relationship: ________________ S.S.N.:____________________ DOB:________________

Dental Insurance:

Insurance Company:________________________ Phone number:________________________

Group number: ________________ ID number: ______________________________

Insured's Name: ____________________ Insured's DOB:__________ Insured's SSN:______________

Insured's Employer:____________________ Insured's Relationship to Patient:________________

Getting to Know You

Is another member of your family a patient here? If so, Name: ______________________________

Relation: ______________ How did you hear about us?______________________________

Whom may we thank for referring you to our office? ______________________________

Consent for treatment

I hereby authorize the doctor or other designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of my dental needs.

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.

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 time of service unless prior arrangements have been made. I understand that a 1.5% (18%APR) or min of $5.00 service charge may be added to my account if the balance is not paid in full within 60 days. I further understand that in the event of a returned check, a $45.00 fee will be assessed. I also understand and agree if this account goes into default, I will be responsible for all court costs, attorney fees and collection fees (of not less than 33.3% of outstanding balance).

I understand that my doctor's time is important and that by making an appointment she has reserved time on her schedule just for me that could be used to see other patients in need. I understand that a $50 broken appointment fee may be charged to my account unless I give a 24-hour notice of cancellation.

I have read and understand the above policy, and I agree to the terms above.

Patient signature ____ **Date** ____________

(If patient is under 18 sign below)

Parent/responsible party's signature ____**Date** __________