Responsible Party Information

Name_____ Relation to Patient_____
___Male ___Female ___Married ___Single ___Child ___Other

Social Security #_____ Birth Date_____
Home Phone_____ Work Phone_____
Address_____
_____

Insurance Information

Primary
Name of Policy Holder_____ Patient? ___Yes ___ No
Policy Holders Birth Date_____ Social Security #_____
Policy Holders Address_____
Policy Holders Employer_____ Phone #_____
Address_____
Patient's relationship to Policy Holder ___Self ___Spouse ___Child ___Other_____
Insurance Plan Name and Address_____
_____

Secondary
Name of Policy Holder_____ Patient? ___Yes ___No
Policy Holders Birth Date_____ Social Security # _____
Policy Holders Address_____
Policy Holders Employer_____ Phone # _____
Address_____
Patient's relationship to Policy Holder ___Self ___Spouse ___Child ___Other_____
Insurance Plan Name and Address_____
_____

Consent for Treatment

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine; due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that finance charges of 1 & ½ % (18 % APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained in this form.

_____

Patient_____ Date_____ Witness_____
Parent/Responsible Party_____ Relation to patient_____

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