MEDICAL ALERTS	ALLERGIES

Today's Date: / /

PATIENT INFORMATION

Last Name:	First:		Middle:	Marital status (circle one)		
Address:				Single / Mar / Div / Wid		
City:	State:	Zip:	Birth date:	Age:	Sex:	
SSN:	Employer:		/ /		❑ M	❑ F
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )			
Dental/Medical Insurance Company:		E-Mail:				
Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other						

GUARANTOR / PRIMARY INSURANCE INFORMATION

Last Name:	First:		Middle:	Marital status (circle one)		
Address:				Single / Mar / Div / Wid		
City:	State:	Zip:	Birth date:	Age:	Sex:	
SSN:	Employer:		/ /		❑ M	❑ F
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )			
Dental/Medical Insurance Co:		Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other				

SECONDARY INSURANCE INFORMATION

Last Name:	First:		Middle:	Marital status (circle one)		
Address:				Single / Mar / Div / Wid		
City:	State:	Zip:	Birth date:	Age:	Sex:	
SSN:	Employer:		/ /		❑ M	❑ F
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )			
Dental/Medical Insurance Co:		Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other				

How did you hear about our office? _____

IN CASE OF EMERGENCY

Name:	Relationship to patient:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )

CONSENT:

*I consent for the purpose of examination, x-rays, impressions, photographs, videos, and other tests that will be explained and agreed to as necessary for the purpose of diagnosis, identification, predetermination of insurance or demonstration for education or science. I authorize the release of my records to a doctor or doctors of my choosing as may be deemed for the purpose of consultation. I authorize payment directly to the above name dentist of the group insurance benefits otherwise payable to me if allowed by my plan. (Some PPO's will not pay directly regardless of authorization) I understand that I am responsible for all costs of dental treatment, regardless of insurance benefits. I also understand it is likely and probable that my insurance benefits will be less than the amount billed. I acknowledge it is my responsibility to pay that portion not covered by insurance (estimated co-pay) at the time charges are incurred. I will pay for any collections or legal charges incurred in the collection of uncovered charges should I fail to pay them during the agreed upon time. I acknowledge that this office incurs a loss if I do not keep my appointments, and I can be charged a fee of $50 or 20%, whichever is greater for late or missed appointments. I acknowledge that a 24-hour notice is required for any cancellation on a 1 hour appointment and a 48 hour notice for any appointments greater than 1 hour. I acknowledge that a 20% reservation fee is due at the time of scheduling treatment.

_____ _____

Patient's signature **Date** **Witness signature** **Date**