PATIENT ACQUAINTANCE FORM

PATIENT NAME: ____
Last First MI

Date of Birth: __________________

Address:____
Street City State Zip Code

Home Phone: ________________________ Mobile Phone: _________________________
Social Security No: ____________________ Business Phone:________________________
Employer: __________________________ E-mail:_______________________________
Spouse Name: _________________________ Business Telephone: ______________________
Spouse Employer: ______________________

Whom May We Thank For Your Referral? _______________________________________

INSURANCE INFORMATION

DENTAL INSURANCE:

Subscriber Name: ___________________________
Insurance Co: ______________________________
Insurance Phone:____________________________
Insurance Co. Address: ______________________
Subscriber SSN/ID#:________________________
Subscriber DOB: _________________________

Second Insurance Company Information (if applicable)
List Policy Holder Name, Insurance Co. Address, Telephone, Policy No, Group No.:
____

CONSENT FOR TREATMENT

1. I hereby authorize the Doctor 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 the patient's dental needs.

2. 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.

3. 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.

4. Lastly, I authorize my insurance benefits to be paid directly to the Doctor. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I also understand in the event that payments are not received by agreed upon dates, the balance may be added to my account.

SIGNED: ____ DATE: _________________________