Polished
GENERAL DENTISTRY

PATIENT'S NAME FIRST LAST		**DATE OF BIRTH**	**SEX**	SSN
PATIENT'S ADDRESS STREET CITY STATE ZIP			**HOME/CELL PHONE (H) (C)**	
MARITAL STATUS	**PATIENT'S/GUARDIAN'S EMPLOYER**	**OCCUPATION**	**EMAIL**	
WORK ADDRESS STREET CITY STATE ZIP			**WORK PHONE OK TO CALL WORK Y N**	
PATIENT'S NAME FIRST LAST		**SPOUSE'S EMPLOYER**	**OCCUPATION**	
WORK ADDRESS STREET CITY STATE ZIP			**WORK PHONE OK TO CALL WORK Y N**	
PERSON WE MAY CONTACT IN CASE OF EMERGENCY (OTHER THAN FAMILY HOME) NAME RELATIONSHIP WORK # CELL #				
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE		**WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?**		
INSURANCE COVERAGE Y N	**INSURANCE COMPANY NAME**	**INSURANCE ADDRESS**		
SUBSCRIBER'S NAME	**PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT**	**SUBSCRIBER'S DATE OF BIRTH**	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER	**EMPLOYER (IF DIFFERENT FROM ABOVE)**	**EMPLOYER ADDRESS**		
INSURANCE COVERAGE Y N	**INSURANCE COMPANY NAME**	**INSURANCE ADDRESS**		
SUBSCRIBER'S NAME	**PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT**	**SUBSCRIBER'S DATE OF BIRTH**	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER	**EMPLOYER (IF DIFFERENT FROM ABOVE)**	**EMPLOYER ADDRESS**		

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicted. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment of dental service 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.
4. I understand that, where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient_____ Date_____

Parent or Responsible Party_____ Relationship to patient_____

For office use_____ Date_____