Patient Information					
	Date:				
	I □ Single □ Child □ Other				
Social Security #: Birth Date:					
Phone (Home): (Work):					
Preferred appointment times: Morning Afternoon Ev	-				
Address:Street	Apartment #				
City State					
E-Mail Address:					
Employment	Information				
The following is for the patient Employer Name:	e following is for the patient in th				
Address:					
Street City	State Zip Code				
Referral In:					
Whom may we thank for referring you to our practice? ☐ An					
□ Insurance □Yellow Pages □ Newspaper, (which one?) □ Other	Light Magazine (which one?)				
Name of person or office referring you to our practice:					
- Table 5. possess of smooth section by the section production.					
Spause or Deepensible Party Information					
Spouse or Responsible Party Information The following is for: the patient's spouse the person responsible for payment The following is for: the patient's spouse the person responsible for payment					
Name:	Married □ Single □ Child □ Other				
Social Security #: Birth Date:					
Phone (Home): (Work):	Ext: Best time to call:				
Address:	• • • •				
Street	Apartment #				
City	State Zip Code				
Employment Information					
The following is for the patients spouse or the person responsible for payment	t .				
Employer Name:	Occupation:				
Street City	State Zip Code				
Cancellation Notice					
To be able to serve all patients with the same commitment, keep in mind that schedules appointments are extremely precious. If you cannot keep a scheduled appointment a 24hour cancellation notice by you is required. We do realize that certain emergencies are unavoidable.					
Missed appointments without a 24hr notice will be charges at the rate of \$50 for each hour scheduled. Saturday missed appointments will be charged at the rate of \$75 for each scheduled hour. Please remember that other patients may have desired that time					

Patient Initials: _____

Dental and Medical Insurance Information					
Dental Name of Insured:			is insured a pati	ient? □ Yes □ No	
Name of Insured: Insured's Birth Date:	First	MI	Group #:	= 100 = 110	
Insured's Address:			_		
Insured's Employer Name:				Zip Code	
Address:					
Patient's relationship to insured:	□ Self □ Spouse □	Child Dothe	State E r	Zip Code	
Insurance Plan Name and Address:	•				
Medical Name of Insured:			is insured a pati	ient? □ Yes □ No	
Insured's Birth Date:	First ID #:	MI	Group #:		
Insured's Address:					
Insured's Employer Name:		City	State	Zip Code	
Address:				Zip Code	
Patient's relationship to insured:	☐ Self ☐ Spouse ☐	Child Othe	er		
Insurance Plan Name and Address:					
	Consent for Serv	· /D	4 B .!!		
treatment mutually agreed upon and to uconsent that doctor chooses and employ informed on findings and advised of the strendered. As a condition of my treatment, finant given an opportunity to select the plan the previous financial arrangements, must be annum) on the unpaid balance will be chastisfied. I understand that the fee estimate list examination, unless the fees have been charged directly to me and I'm personally and assist in making collections from insoffice cannot render services on the assidecide not to contribute or pay less than In consideration for the professional reasonable value of said services to said made, I further agree that the reasonable after treatment is rendered. I further agree of any further term or condition and I furt I grant my permission to you or your this form. To the best of my knowledge, all of the changes in my health status or inform I have read the above conditions of tremedical information for the purposes You may review our "Notice of Privacy Pthis Consent. Please verify that you have	such assistance as deen suggested treatment plan cial arrangements must be at best suits my needs. As a paid for at the time servarged on all accounts exceed for this dental care can changed by my insurance of responsible for payment urance companies, and wamption that all charges were the "guesstimate", I, the preservices rendered to me, I Doctor, or his assignee, a value of said services shee that a waiver of any brown her agree to pay all costs assignee, to telephone me the preceding answers are action on these forms, I peatment and payment are of Treatment, Payment ractices" for additional information in the services in a different and payment are controlled to the suggestion of the payment are controlled to the suggestion of the payment are controlled to the suggestion of the payment and payment are controlled to the suggestion of the payment are controlled to the suggestion of the payment are controlled to the suggestion of the payment are controlled to the payment and payment are controlled to the payment and payment are controlled to the payment are controlled t	ned fit to provide. After mutual age made in advarull emergency de ices are rendere reeding 60 days, on only be extended acarrier sooner. If or such service carrier sooner, if or such service it any such that it me said hall be as billed the each of any time and reasonable e at home, on condition in the indication about 1 days and the about 1 days are armation are armatically a days are armatically armatically are armatically armati	recommended treatmy remember on the treatmy remember on the treatmy remember on the treatmy remember on the treatmy remember of the properties of the treatmy remember of the treatmy defends on the treatmy remember of the t	ent. Following diagnosis I'll be nent plan, treatment will be Initials arious financial options and ental services rendered without 1½% per month (18% per ten financial arrangements are months from the date of the ental services furnished are me prepare all insurance forms count. However, this dental should the insurance company rence owed. The to pay therefore the if user arrangements was not me, in writing, within 30 days der shall not constitute a waiver libe instituted hereunder. It to discuss matters related to the count of th	
uns Consent. Please venity that you have	received a copy of our N	once by placing			
Signature of patient, parent or guardian			Date:	_	
			Date:	_	
Signature of guarantor of payment/respo	nsible party			_	