RESPONSIBLE PARTY DEMOGRAPHIC AND INSURANCE INFORMATION

(Confidential information-Please fill out completely)

NAME _____ **MI** ____ **LAST NAME** _____ **DATE** _____

HOME TELEPHONE# _____ **CELL PHONE#** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

EMPLOYER _____ **EMPLOYER TELEPHONE** _____

EMPLOYER ADDRESS _____ May we contact you at work? Yes No

DATE OF BIRTH _____ REFERRED BY _____

SOCIAL SECURITY # _____ **BANK NAME** _____

E-MAIL ADDRESS _____ **COLLEGE-IF STUDENT** _____

EMERGENCY CONTACT _____ **TELEPHONE** _____

SPOUSE NAME _____ **SOCIAL SECURITY #** _____

EMPLOYER _____ **EMPLOYER TELEPHONE** _____

EMPLOYER ADDRESS _____ **DATE OF BIRTH** _____

PRIMARY DENTAL INSURANCE INFORMATION

EMPLOYER NAME _____ EMPLOYEE NAME _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____
INSURANCE CO NAME _____ ADDRESS _____
GROUP # _____ MEMBER I.D. # _____

2ND DENTAL INSURANCE INFORMATION

EMPLOYER NAME _____ EMPLOYEE NAME _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____
INSURANCE CO NAME _____ ADDRESS _____
GROUP # _____ MEMBER I.D.# _____

MEDICAID/MEDICAL ASSISTANCE ID# _____

Consent for Treatment and Financial Agreement

I authorize any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis and to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my (or the patient's) treatment. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that a Finance Charge of .66% per month will be added to any balance over 60 days. This is an Annual Percentage Rate of 8%. In the event of default I understand that I am financially responsible for collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____

Parent or Responsible Party _____ Date _____