Medical Alert for Office Use

Welcome to our Practice! Please fill out the following patient information –Thank you.

Name____
LAST FIRST MIDDLE INITIAL NICKNAME/PREFERRED NAME

Address____
STREET

____
CITY STATE ZIP

How did you hear about us?

Employer_____________________________ Drivers License_____________________________
Date of Birth _________________________ Social Security # ___________________________
Phone #'s Home(________)______________ Email:_____________________________________
Work(________)______________
Mobile (________)______________

❏ Male ❏ Female ❏ Child

Emergency: Name_____________________________ Phone (________)____________________
Relation to emergency contact: ____

Insurance

Primary Dental Carrier

Subscriber Name ____________________ Social Security # ______________ DOB______________

Employer ____________________________ Insurance Co. ___________________________________

Insurance Co. Phone # _________________ Group # _______________________________________

Relation to patient_____________________

Secondary Dental Carrier

Subscriber Name ____________________ Social Security # ______________ DOB______________

Employer ____________________________ Insurance Co. ___________________________________

Insurance Co. Phone # _________________ Group # _______________________________________

Relation to patient_____________________

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred from dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature ____Date ____________________

Treatment and Payment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify that the statements regarding my medical condition listed are correct to the best of my knowledge.
Payment for all treatment and services rendered are my responsibility. Should my account go to collections I am responsible for the 40% collection fee.

_______________________________________ ____________________
PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_______________________________________ ____________________
PARENT/ GUARDIAN SIGNATURE DATE