



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(_____) Male Female Child

Mobile (_____) _____

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 _____



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