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WELCOME

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

All professional services rendered are charged to the patient and the patient is personally responsible for payment of fees at the time of service unless other arrangements have been made in advance.

RESPONSIBLE PARTY INFORMATION (IF PATIENT UNDER 18 YEARS OF AGE)

Name: _____
Residence:_____
Mailing Address:_____
Relationship to patient:_____
Home phone #:_____
Work phone #:_____

EMERGENCY INFORMATION
Name of nearest relative not living with you: _____
Addtress:_____
Home phone#:_____Work phone #_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to my dependant or me during the period of such dental care to third party payers and health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor:_____ Date_____