PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

NAME

SPOUSE

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

SOCIAL SECURITY NO.

DATE

NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NO.

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NO.

ADDRESS

CITY | STATE | ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photograph, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____ s dental needs.

2. Upon such diagnostic, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I hereby give Dr. W. Green the absolute right and permission to use photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

4. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. In consideration of the services provided to the patient, I hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payments shall be made in full within thirty (30) days of discharge.
   In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) and/or $2 billing fee may be added to my account. I agree that in the event of default in payment, reasonable costs of collection, equal to fifty (50) percent of the delinquent balance, and/or reasonable attorney fees may be added to the amount due on the account.

Patient_____Date_____Witness_____

Parent or Responsible Party_____Relationship to Patient_____