

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext.: \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_ City State Zip Code

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is the insured a patient?  yes  no  
Last First MI

Insurer's Birth Date: \_\_\_\_\_ S.S.#: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is the insured a patient?  yes  no  
Last First MI

Insurer's Birth Date: \_\_\_\_\_ S.S.#: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Consent for Treatment

I hereby authorize the doctor or designated dental staff to take x-rays, study models, photographs, and other diagnostic aids deems appropriate by the doctor to make a complete and thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatments mutually agreed upon by me and to employ such assistance required to provide the proper care.

I agree to the use of anesthetics, sedatives and other medications 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.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Responsible Party's Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_