

***ADULT INFORMATION***

Date: \_\_\_\_\_

Full Name of Patient: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_  Male  Female

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone number: \_\_\_\_\_

Name and Address of Employer: \_\_\_\_\_

Who can we thank for your referral? \_\_\_\_\_

Do you have Dental Insurance?  Yes  No

Name and Address of Insurance Company: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

Social Security Number of Insured Person: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Group Number or Other Pertinent Information: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**CONSENT:**

The undersigned hereby authorizes the Doctor to take X-rays, study models, take photographs, or use any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all kinds of treatment, prescribe medication and therapy, which may be useful in the diagnosis and treatment of:  
(Name of Patient) \_\_\_\_\_

I further authorize and consent that the Doctor may choose and employ assistance as she deems fit. It is also my understanding that responsibility for payment of the Dental Services provided in this office, for myself or any of my dependents is mine. Payment is due and payable at the time of those services. Furthermore, I understand that a 1 1/2% finance charge (18% annually) will be added to any balance after completion of planned treatment. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_