## **Patient Information**

	Patient Name:Last,				(D. C. 13)	Date:
Phone (Home):	Last,		First,	MI	(Preferred Name)	
Preferred appointment times: AM PM Any Time M T W Th  Address:	Social Security #:		Birthdate: _	/		Gender: M F
Address:	Phone (Home): ()	(Work)	:()		Ext: Cell:	
Spouse or Responsible Party Information	Preferred appointment times: AM	I PM	Any Time	M	T W Th	
Spouse or Responsible Party Information  The following is for: Spouse Person responsible for payment  Name:	Address:	3	1		Marital Status:	M S D W
Spouse or Responsible Party Information  The following is for: Spouse Person responsible for payment  Name:					E-Mail:	
The following is for: Spouse Person responsible for payment  Name:	City	ST	Z	ip		
The following is for: Spouse Person responsible for payment  Name:		Spouse o	r Resnonsible Pa	rty Inform	ation	*
Name: Male Female Married Single Child Other  Social Security #:	The fellowing is for.				ation.	
Social Security #: Birth Date:/	4	Person re	esponsible for pay	ment		
Phone (Home): (	Name:Male Female	Married	Single Ch	aild Othe	er	
Phone (Home): (						
Address:  City ST Zip  Employment Information  The following is for: Patient Person responsible for payment  Employer Name: Occupation:  Address: Street City/ST Zip  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time serviced. Patients who carry dental insurance understand that all dental services are charged directly to the patient of the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be res any balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to	Social Security #:		Birth Date:	/	/	
Employment Information  The following is for: Patient Person responsible for payment  Employer Name: Occupation:  Address: Phone: ()  Street City/ST Zip  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time serviced depends upon reimbursement from the patients for the costs incurred in their care at the time serviced depends upon reimbursement. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be research and be participate of the particip	Phone (Home): ()		(Work): (			Ext:
Employment Information  The following is for: Patient Person responsible for payment  Employer Name: Occupation:  Address: Phone: ()	Address:	3 5 5				
Employment Information  The following is for: Patient Person responsible for payment  Employer Name: Occupation:  Address: Phone: ()  Street City/ST Zip  Whom may we thank for your referral?  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time servidered. Patients who carry dental insurance understand that all dental services are charged directly to the patient of the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept assistenefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsed benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsed by the patient will be patient will be patient will be responsed by the patient will be responsed by the patient will be patient will be responsed by the patient will be patient will be responsed by the patient will be respon	· · · · · · · · · · · · · · · · · · ·		1			
The following is for:  Patient  Person responsible for payment  Occupation:  Address:  Street  City/ST  Zip  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time servicedered. Patients who carry dental insurance understand that all dental services are charged directly to the patient of the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept asset benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsible for the treatment will be responsible for a period of 6 months from the date to the participate of the costs incurred in their care at the time service of the costs i	City	ST	Zip			
Employer Name:		E	Employment Info	rmation		
Address: Phone: (	The following is for: Patient	Person	n responsible for p	payment		
Address: Phone: (	F-1			0		
Whom may we thank for your referral?  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time servidered. Patients who carry dental insurance understand that all dental services are charged directly to the patient the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept assistenefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsible for treatment will be honored for a period of 6 months from the date to						
Whom may we thank for your referral?  Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time servidered. Patients who carry dental insurance understand that all dental services are charged directly to the patient the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept assistenefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsible for treatment will be honored for a period of 6 months from the date to	Address:Street	City/S	T	Zip	Phone: (	
Consent for Services  is practice depends upon reimbursement from the patients for the costs incurred in their care at the time serviced. Patients who carry dental insurance understand that all dental services are charged directly to the patient the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept assistenefits for the treatment covered. We do not participate in any insurance plans, and the patient will be responsible for treatment will be honored for a period of 6 months from the date to						
is practice depends upon reimbursement from the patients for the costs incurred in their care at the time serviced. Patients who carry dental insurance understand that all dental services are charged directly to the patient the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be resum balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to	Whom may we thank for your referra	1?				· ·
is practice depends upon reimbursement from the patients for the costs incurred in their care at the time serviced. Patients who carry dental insurance understand that all dental services are charged directly to the patient the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be resum balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to	*		S			
dered. Patients who carry dental insurance understand that all dental services are charged directly to the pate the or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be res- any balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to			onsent for Se	rvices		
t he or she is personally responsible for payment. As a courtesy, we will file dental insurance and accept ass benefits for the treatment covered. We do not participate in any insurance plans, and the patient will be res any balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to						
any balance due. Any fee quoted for treatment will be honored for a period of 6 months from the date to						-
			^ ^	•	•	_
					-	
nsent for exam and treatment is given and I understand that I have the opportunity to ask for clarification of see as they become necessary. I may refuse any treatment understanding it may result in loss of teeth and furth						
es as they become necessary. I may refuse any treatment understanding it may result in loss of teem and further cations. I have read the above conditions of treatment and payment and agree to their content.					•	

Signature of patient, parent or guardian, guarantor of payment/responsible party.